AB1241 MOST PREVALENT COMORBIDITIES IN PRIMARY SJÖGREN'S SYNDROME IN A HISPANIC POPULATION

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Background: Comorbidities are an important issue to consider in patients with rheumatic diseases (RD), as well as the clinical assessment of the autoimmune disease. Looking for concomitant diseases is a necessary step for a global approach of the rheumatic patient, knowingly that some diseases are more frequent in patients with RD than in the general population and could influence the course of RD and achievement of treatment goals[1]. Despite this, there is a need of new evidence about primary Sjögren's Syndrome (pSS) comorbidities and their association with clinical outcomes.

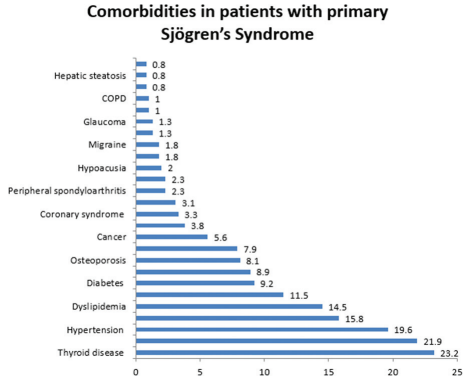

Figure 1

Objectives: To determine the prevalence of comorbidities in patients with pSS in mexican population.
Methods: This was a national, multicenter, cross-sectional, and observational study. We included 393 patients with pSS, diagnosed according to the American-European Consensus Group (AECG) criteria 2002 or ACR/EULAR 2012 criteria. Comorbidities, serological profile of autoantibodies, Schirmer's test, sialometry and histopathological assessment from minor salivary gland biopsies reported in the medical records were evaluated by a rheumatologist. The comparisons between the study groups were carried out using the two-tailed Student's t test, $\chi 2$ test, and unidirectional. A value of $p<0.05$ was considered statistically significant.
Results: At least one comorbidity were reported in 310 (78.9%) patients, 2 to 4 comorbidities were reported in 183 (46.6%), and only 18 (4.6%) had a least 5 comorbidities. Thyroid disease was the most frequent comorbidity, observed in 91 (23.2%) subjects, being hypothyroidism the main cause. Smoking (21.9%) and hypertension (19.6%) were in second and third place. Psychiatric disease was present in 62 (15.8%) patients being depression and anxiety disorders the most frequent, appearing in 49 (79%) and 12 (19.35%) patients respectively. Regarding malignancy, we documented 10 (2.5%) patients with lymphoma, and 4 (1%) patients with breast cancer. The rest of comorbidities are shown at Figure 1 and Table 1. There was no significant difference for each variable measured between the groups except for the mean age (p= 0.001).

Table 1. Demographic and clinical variables. *n=393:*

Variable	***Comorbidities***	***No comorbidities***	
	n= 310	***n=83***	*P*
Age years, mean(SD)	*58.52 (13.12)*	*48.57 (12.52)*	*0.001***
Female gender, n (%)	*297 (95.8)*	*80 (96.4)*	*0.812*
(+) Anti-Ro/SSA, n (%)	*194 (62.6)*	*59 (71.1)*	*0.139*
(+) Anti-La/SSB, n (%)	*139 (44.8)*	*38 (45.8)*	*0.867*
(+) Schirmer test, n (%)	*210 (67.7)*	*50 (60.2)*	*0.102*
Abnormal sialometry,n (%)	*180 (58.1)*	*47 (56.6)*	*0.946*
(+) GSM biopsy, n (%)	*228 (73.5)*	*66 (79.5)*	*0.140*
Use of corticosteroids, n (%)	*113 (36.5)*	*27 (32.5)*	*0.430*

GSM; Minor salivary gland. P; asymptotic significance,** statistical significance
Conclusion: The systematic evaluation of comorbidities in patients with pSS is essential for an integral management. Physicians should be aware that these conditions might directly impact quality of life, prognosis, treatment response and healthcare costs. We encourage further research for the identification of new approaches in benefit of the patients.

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Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.1608

AB1242 COLCHICINE USE DURING PREGNANCY: CASE REPORTS

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Background: If used during pregnancy it is known that colchicine passes through the placenta to the fetus[1]. Although it has been shown to increase the risk of congenital malformations in animal studies, there is no increase in undesirable results in humans[2]. The guidelines indicate that the use of colchicine in pregnancy and lactation is appropriate[3,4]. However, data from clinical studies and case reports for the use of colchicine during pregnancy are not sufficient.
Objectives: The aim of this study was to evaluate pregnant and/or nursing patients who were consulted to our teratology information center for colchicine use.
Methods: Colchicine treated patients during pregnancy was included in this study. Patients consulted to our information service between 2012-2018 were evaluated for risk assessment of colchicine. Information regarding pregnancy outomes was recorded by telephone interviews with patients.
Results: Indications for colchicine use in 34 cases (33 patients; one of them had pregnancy twice) were familial Mediterranean fever (n=21), Behcet's disease (n=9), systemic lupus erythematosus (n=1), ankylosing spondylitis (n=1) and vasculitis (n=1). Of the cases, 22 used the drug in pregnancy and lactation, 12 used only in pregnancy period. Of the 34 pregnancies, three had elective termination of pregnancy (the reason in one case was cytomegalovirus infection, the other is unplanned-unwanted and the other was unknown) and three had spontaneous abortion.Twenty eight had given birth, 19 of them were term and 9 of them were preterm. Delivery mode of 18 were caesarean and 10 of them were vaginal birth. A total of 30 live birth infant (two twins) exposed to colchicine due to their mother's treatment. Twenty three infant was healthy and the remaining 7 had different problems. Four of them cardiac [minor cardiac septal defect which not needs operation (n=2), pink tetralogy of fallot (n=1), heart valve stenosis (n=1)], nephrolithiasis, inguinal hernia and death (respiratory distress after birth) (table 1).
Conclusion: Currently, systematic review and meta-analysis driven data suggests that colchicine does not significantly increase the incidence of foetal malformations or miscarriage and colchicine for FMF should not be withheld on this basis during pregnancy. Although the causality between colchicine use and the above reported mostly cardiac and rare problems such as tetralogy of fallot is not proven, the contribution of colchicine cannot be ruled out totally and should be beard in mind in cases of colchicine use for indications other than FMF or Behçet's disease.

Table 1. List of unhealthy infant of colchicine exposure in pregnancy (TO: Through pregnancy)

Problems	Diagnosis	Exposure time	Colchicinedetails mg/d	Delivery mode, time w	Gender/ Birth weight g	Concomitant medication
Nonopere cardiac septal defect	BD	first 8 week	1	Vaginal,40	M 3400	-
Nonopere cardiac septal defect	Vasculitis	first 20 week	1	C/S, 31	Unknown	Corticosteroid
Heart valve stenosis	BD	TO	1-1.5	Unknown	Unknown	-
Pink tetralogy of fallot (opere)	FMF	TO	3-4	C/S, 38	M 3200	-
Inguinal hernia	FMF	TO	2	C/S, 33	M 1370	Corticosteroid
Nephrolithiasis	BD	TO	0.5-1	C/S, 38	M 3640	Azathioprine, Corticosteroid
Death	AS	first 8 week	Unknown	C/S, 34	Unknown	Sulfadiazine

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Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.3999

AB1243 OBESITY, METABOLIC SYNDROME AND OTHER COMORBIDITIES: INFLUENCE ON RHEUMATOID ARTHRITISAND PSORIATIC ARTHRITIS ACTIVITY AND QUALITY OF LIFE

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Background: Patients with rheumatic inflammatory conditions have an increased risk of premature death due to cardiovascular causes. It can be explained by the unfavourable interaction between the inflammatory process and the traditional cardiovascular risk factors. In obesity, especially if visceral, and in rheumatic diseases, there is production of pro-inflammatory cytokines, which contributes to an increase in cardiovascular risk. The influence of body mass index (BMI) on the evolution, activity and quality of life in rheumatoid arthritis (RA) and in psoriatic arthritis (PsA) has been proven. However, studies evaluating the influence of the abdominal circumference (AC) and metabolic syndrome (MS) are meagre.
Objectives: To assess the influence of BMI, AC and MS, on disease activity and quality of life in RA and PA, using parameters of inflammatory activity (sedimentation rate (SR) and C-reactive protein (CRP), Activity Score (DAS28), Visual Analogue Pain Scale (VAS) and Health Assessment Questionnaire (HAQ) and to compare patients with RA and PA.
Methods: A cross-sectional study, including 150 patients with RA, diagnosed according to the ACR/EULAR criteria and 75 patients with PsA (CASPAR criteria). Assessment of weight, height, AC, SR and CRP of all patients, clinical and demographic data collection. The presence of MS was assessed according to WHO definition. Participants completed HAQ and disease activity was measured by DAS28. SPSS was used for the statistical analysis, significance level was 2-sided $p<0.050$.
Results: Age, duration of illness, schooling and professional class were similar in RA and PsA. In RA there was a predominance of females (78.7%), while in PsA a predominance of males (53.3%). There were no differences between the quality of life (by HAQ), or in the disease activity (by DAS28 or by inflammatory parameters). PsA patients had significantly higher BMI and AC. The number of comorbidities was higher in cases of PsA. Dyslipidaemia and hyperuricemia were significantly more frequent in this group of patients. Independently the underlying pathology (RA or PsA), the number of comorbidities correlated positively with DAS28, with HAQ, CRP and SR.
In RA group, there was a positive correlation of both BMI and AC with HAQ, also MS associated the highest HAQ values. Overweight/obesity ($BMI \geq 25 kg/m^2$) were associated with at least one painful joint. Still, the risk of having at least one swollen joint was 3.4 times higher in patients with increased AC (95% CI: 1.08-10.39). There was an association between the BMI and AC and the CRP value. Patients with $BMI \geq 25$ kg/m^2 and with increased AC had DAS28 values significantly higher. MS was associated with significantly higher SR.
In PsA group Patients with MS had higher CRP values, more joint pain and higher disease activity according to DAS28. Patients with $BMI \geq 25 kg/m^2$ also had more painful joints and higher CRP values. None of the patients with normal BMI had swollen joints, however 20.4% of overweight patients had at least one swollen joint. There was no association between the disease phenotype and BMI, AC or MS.
Conclusion: In this study there was a higher prevalence of classic cardiovascular risk factors in patients with PsA. The number of comorbidities showed to influence inflammatory parameters, disease activity and quality of life. We found that BMI, AC and MS are associated with disease activity, which may be improved by weight reduction and control of comorbidities. Therefore they should be considered in the treatment of rheumatologic diseases.

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Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.3461

AB1244 TUBERCULOUS SPONDYLODISCITIS : A CASE SERIES ANALYSIS

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Background: Spinal tuberculosis or Pott's disease is one of the many manifestations of active tuberculosis and is still common in Mediterranean countries such as Tunisia with high endemicity. Definitive diagnosis of tuberculous spondylodiscitis requires the identification of Mycobacterium tuberculosis.
Objectives: We aimed to describe clinical, laboratory, diagnostic and therapeutic features of spinal tuberculosis.
Methods: Retrospective study including 64 patients followed up in our department between 1999 and 2019. Clinical, biological and radiological data were collected. Therapeutic outcome was studied.
Results: We studied 64 patients included 35 women and 17 men with a mean age of 56 years old [16 - 86]. Seven patients had a contact with Mycobacterium Tuberculosis Bacilli and 3 patients had a history of pulmonary tuberculosis. The median delay of consultation was 6 months. Inflammatory back pain was found in 79%. Other clinical symptoms: 27.4% fever, 40.3% night sweats, 74.1% impaired general condition. Neurologic deficiency was noticed in 16.1% of cases. 7 patients had another localization of tuberculosis. The inflammatory biological syndrome was found in 92% of cases. The lumbar spine was involved in 58% of patients, followed by the dorsal spine (41.9%) and cervical spine (9.67%). The spondylitis was multifocal and multi-stage in 24.19% of cases. Plain