Regarding TTV, one study showed persistent seroresponse in patients treated with TNFi; a second study showed no difference between MTX and RTX in response to T-cell dependant protein Ag TTV.
Two studies reported no significant difference in efficiency or tolerance in patients accidentally revaccinated against yellow fever under TNFi.
Conclusions: These observations highly suggest that an effective vaccination for patients treated with MTX, RTX, and ABA should necessitate a therapeutic window or a scheduled treatment spacing, in order to offer the best protection against Influenza and Pneumococcal infection. This might not be necessary in patients under TNFi or TCZ; nevertheless, further studies are necessary to optimize the vaccination modalities.
Disclosure of Interest: None declared
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THU0159 RHEUMATOID ARTHRITIS MAY NOT INFLUENCE EATING BEHAVIOURS CHARACTERISTICS

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Background: Patients with rheumatoid arthritis (RA) have an increased risk of obesity and cardiovascular disease compared with the general population (1). Eating behaviours may play an important role in obesity and cardiovascular disease.
Objectives: We hypothesised that RA patients have impaired eating behaviours that may have a role in obesity. For evaluating this hypothesis, we compared eating behaviours of patients with RA, osteoarthritis (OA) and healthy controls.
Methods: One hundred and fifty-seven RA patients (M/F: 23/134) who fulfilled the 2010 American College of Rheumatology (ACR) RA classification criteria, 31 hand OA patients (M/F: 1/30) who fulfilled 1990 ACR hand OA criteria and 60 healthy controls (M/F: 9/51) were enrolled to the study who applied to Kartal Dr. Lutfi Kirdar Training and Research Hospital Rheumatology outpatient clinic. Eating behaviours was assessed by the Three-Factor Eating Questionnaire (TFEQ).Demographic data, smoking status, co-morbidities, anthropometric measurements, VAS pain score were analyzed.
Results: There were no differences between three groups in demographic features and anthropometric measurements (table1). Moreover, there were no differences between three groups in cognitive restraint and emotional eating scores.Although,healthy controls had significantly higher uncontrolled eating scores than the RA group ($p<0.05$), uncontrolled eating scores of all three groups were lower than Turkish people average scores (2) (table2).

Table 1. Demographic and Anthropometric features of study groups

	RA (n=157)	OA (n=31)	Healthy Controls (n=60)	*p*
Age	51.00 (40.00–57.50)	50.00 (46.75–62.00)	48.00 (39.25–53.75)	0.06
Gender (M/F)	23/134 (14.6/85.4)	1/30 (3.2/96.8)	9/51 (15.0/85.0)	0.21
Education (year)	5.00 (5.00–10.00)	5..00 (5.00–11.00)	5.00 (5.00–11.00)	0.42
Smoking ((%)	24.2	23.3	20.7	0.86
Co-morbid disease	55.8	64.5	49.2	0.37
Lenght (cm)	160.00 (155.00–165.00)	157.00 (155.00–160.00)	160.50 (157.00–166.75)	0.06
Weight (kg)	75.00 (67.00–85.00)	77.00 (66.00–85.00)	74.00 (64.00–84.50)	0.73
BMI (kg/m^2)	29.150 (25.50–33.20)	31.100 (27.12–35.07)	27.550 (23.87–32.77)	0.15
VAS pain (0–100)	10.00 (0.00–30.00)	10.00 (10.00–30.00)	N/A	0.07

RA, Rheumatoid Arthritis; OA, Osteoarthritis; BMI, Body mass index; VAS, Visual analog score.

Table 2. Eating behaviours of study groups

	RA (n=157)	OA (n=31)	Healthy Controls (n=60)	*p*
Uncontrolled eating scores	10.00 (8.00–12.00)	10.00 (8.00–13.00)	11.00 (9.00–14.00)	0.047
Cognitive restraint scores	16.00 (13.00–18.00)	16.00 (14.00–19.00)	14.00 (11.25–18.00)	0.075
Emotional eating scores	5.00 (3.00–8.00)	5.00 (3.75–11.00)	4.00 (3.00–7.00)	0.066

Conclusions: This was the first study using the TFEQ in patients with RA. In our study, we found that disease features of RA may had no effect on eating behaviors.
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THU0160 DISEASE MODIFYING ANTIRHEUMATIC DRUGS IN RHEUMATOID ARTHRITIS WITH INTERSTITIAL LUNG DISEASE: A PROSPECTIVE STUDY

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Objectives: To describe the evolution of interstitial lung disease (ILD) in RA patients treated with disease modifying antirheumatic drugs (DMARDs) for 1 year in real clinical practice conditions.
Methods: *Design:* Prospective observational case-series. *Patients:* Patients with RA (ACR/EULAR 2010 criteria) and ILD (American Thoracic Society/European Respiratory criteria) from two centres (Regional Hospital of Málaga and Valme Hospital of Sevilla) were included. *Protocol:* All patients with RA and ILD who visited outpatient clinic from January to December 2015. They were reviewed according to a predetermined protocol for systematic data collection. Resolution Computed Tomography (HRCT),Pulmonary function test (PFT) and echocardiogram were requested for all patients.This visit was marked as v0 (index date). At 12 months (v12) the joint assessment (DAS28), echocardiogram, PTF and HRCT were again evaluated. HRCT's were assessed by the same radiologist with expertise in chest radiology. *Outcomes:* At v12:(1)improvement (ie improvement in FVC$\geq$10% or DLCO$\geq$15% and no radiological progression),(2)non-progression (stabilization or improvement in FVC$\leq$10% or DLCO$<$15% and no radiological progression),(3)progression (worsening of FVC$>$10% or DLCO$>$15% and radiological progression), or (4) death due to ILD. *Variables:* Description of ILD type (Nonspecific interstitial pneumonia/Usual interstitial pneumonia) and lung function by PTF, HRCT.Presence of PTH by echocardiogram and dyspnoea.Collection of adverse events. *Statistical analysis:* Descriptive analysis and Wilcoxon or T test between the v0 and v12. One factor ANOVA between sDMARD,bDMARD and combination therapy groups.
Results: The main characteristics at V0 of the patients (n=22) are shown in the table. Seven patients (31.8%) received a sDMARDs with a bDMARDs; 12 patients (54.5%) in monotherapy with sDMARD, with MTX being the most frequent (34.7%); 3 (13.6%) in monotherapy with bDMARDs (Table 1). Three patients (13.6%) had improvement (1 with MTX, 1 with RTX and 1 with HCX + RTX), 15 patients (68.2%) remained stable (4 with MTX, 3 with LFN, 1 with HCQ, 1 AZA, 1 ABT, 1ABT + SSZ, 2 MTX + ETN, 1 HCQ + RTX, and 1 HCQ + ADA);and 3 (13.0%) got worse of ILD (1 with MTX developed unknown lung mass, 1 with LFN and 1 with LFN + IFX). One patient died during follow-up due to respiratory infection (under treatment with RTX). No patient developed PPH. We did not find significant differences between v0 DAS28 and at 12 months (2.55 [0.75] vs 2.42 [1.22], p=0.567) or in HAQ 1.15 [0.93] vs 1.25 [0.78], p=0.450). There were no significant differences in PTF, HRCT or DAS28 at v12 between sDMARD, bDMARD and combination therapy groups. Four patients (18.2%) had adverse effects: 2 respiratory infections, 1 oral herpes simplex and 1 tooth infection.

VARIABLES	Patients
Sex (Female), n (%)	12 (54.5)
Age (years), mean (DE)	69.4 (7.0)
Smoker, n (%)	4 (18.2)
Body mass index (BMI), mean (SD	28.9 (6.0)
Disease duration (months), mean (SD)	211.9 (131.5)
ILD duration (months), mean (SD)	64.5 (47.1)
Rheumatoid factor, n (%)	21 (95.5)
Anti–cyclic citrullinated peptide, n (%)	21 (95.5)
Erosions, n (%)	16 (72.7)
DAS28, mean (DE)	2.55 (0.7)
HAQ, mean (DE)	1.15 (0.9)
Treatment	
sDMARD, n (%)	19 (86.4)
Methotrexate, n (%)	8 (36.4)
Leflunomide, n (%)	5 (22.7)
Sulfasalazine, n (%)	1 (4.5)
Hydroxychloroquine, n (%)	4 (18.2)
Azathioprine	1 (4.5)
bDMARDs, n (%)	10 (45.5)
Rituximab, n (%)	4 (18.2)
Abatacept, n (%)	2 (9.1)
Etanercept, n (%)	2 (9.1)
Infliximab, n (%)	1 (4.5)
Adalimumab, n (%)	1 (4.5)

Conclusions: Most patients with RA and ILD who are receiving treatment with DMARD (82%)remained stable or improved after at least 1 year of both synthetic and biological DMARD treatment. However, a significant percentage of patients had an adverse outcome. More prospective studies with a greater number of patients are necessary to identify the influence of DMARDs in this evolution.
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