associated with spondyloarthritis (including also IBD) were the most frequent (68 patients, 61%). Focusing on this group, 57.4% were male with a mean age of 49±15.8 years. 73.5% were HLAB27 positive and 76% had radiologic sacroiliitis. In 24 patients (35.3%) the diagnosis of spondyloarthritis was made after the anamnesis in the uveitis unit. The diagnosis was already known in the other cases. The spondyloarthritis subtypes are described in the table.

Diagnosis	n (%)
Ankylosing spondylitis	33 (48.5)
Non radiographic axial spondyloarthritis	13 (19.1)
Psoriatic arthritis	5 (7.4)
IBD spondyloarthritis	5 (7.4)
Peripheral spondyloarthritis	4 (5.9)
Juvenile idiopathic arthritis	4 (5.9)
IBD (without Joint involvement)	3 (4.4)
Reactive arthritis	1 (1.5)
Total	68 (100)

According to the anatomical distribution, 95.6% were anterior uveitis (AU), followed by the intermediate and posterior ones (1,5% both). 85.3% has unilateral involvement and 10.3% bilateral. Relapsing acute AU was the most frequent pattern (73.5%), followed by non-relapsing acute AU (16.2%) and chronic AU (7.4%).

24 patients (35.3%) required treatment with DMARD to achieve uveitis control. The most commonly used drugs were salazopyrine (7 patients), methotrexate (6 patients), mycophenolate (1), and in another 6 patients anti-TNF treatment was started or the previous dose of the biological was adjusted.

The visual acuity (VA) was not perfect (VA≠1 in both eyes) in 35% in the first collected visit. 28% (19 patients) had cataract, and 19% (13) had ocular hypertension. Only 1 patient had bilateral cystoid macular edema. Follow-up data were available for 43 patients and VA was stable in 47%, worsening in 23% and improving in 30% (median follow-up time 23 months, IQR: 6–41)

Conclusions: Our work confirms that in spondyloarthritis the most frequent pattern of ocular involvement is relapsing acute AU. Spondyloarthritis diagnosis was made at the uveitis unit in 35% of patients. More than one-third of patients required systemic therapy for ocular involvement control. Thirty-five percent of the patients had a reduced VA, remaining stable or improving in most, during the follow-up.

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AB0714 DIFFERENTIATING CHARACTERISTICS IN PATIENTS WITH SPONDYLOARTHRITIS WHO HAVE RECEIVED DIFFERENTS ANTI-TNF THERAPIES

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Background: The term spondyloarthritis (SpA) encompass a group of crhonic inflammatory disease with predominant axial involvement. Anti-TNF therapy (AT) has stirred up the management of these diseases. Nevertheless, according to nationwide registries of the drug continuation rate in several countries, the rate of treatment failure is considerable. Nowdays there are insufficient data to evaluate the differences between responders (Resp-AT) and non-responders (Nonresp-AT) to anti-TNF therapy.

Objectives: To compare the main sociodemographic, clinical and analytical features at baseline, after 6 months of treatment and at the end of the first anti-TNF therapy of responders to a first anti-TNF therapy and non-responders to several anti-TNF therapies form our cohort of patients diagnosed with SpA. We also analized the association between drug levels (DL) and antidrug antibody (ADA) in non-responders to several anti-TNF.

Methods: 181 patients were included, 155 (85%) kept receiving their first AT therapy (responders) and 26 (15%) had discontinued at least two different AT therapies. The main demographic features, disease activity (BASDAI, ASDAS, CRP and ESR) were measured at baseline, after 6 months (v-6) and when the first AT was discontinued. Serum drug levels and/or ADA were measured at drug discontinuation of anti-TNF treatment and last visit in non-responders and responders respectively.

Results: The mean age was 55.3±15 and 50±10.8 in the resp-AT and nonresp-AT groups, respectively. The demographic and clinical characteristics of both groups are shown in Table 1. At baseline, a lower BMI was observed in the resp-AT group (25.6±5 resp-AT, 28.7±5 nonresp-AT, p=0.013); 59% and 35% were in concomitant treatment with DMARDS at baseline in the resp-AT and nonresp-AT groups respectively (p=0.032); 33% of the resp-AT were in monotherapy in the last visit compared to 62% of the nonresp-AT when discontinued the 1st AT (p=0.008). There were no differences in BASDAI (5.6±2 resp-AT, 6.1±1.9 nonresp-AT, p=0.2) and ASDAS (3.3±1.1 resp-AT, 3.4±1.1 nonresp-AT, p=0.8) at baseline. In v-6, the resp-AT group had a better clinical response in terms of BASDAI (3.2±2.3 in resp-AT, 4.7±2.4 in nonresp-AT, p=0.004) and ASDAS (1.7±0.9 in resp-AT, 2.7±1.2 in nonresp-AT, p=0.00), as well as in the delta-ASDAS (ΔASDAS) (1.56±1.2 resp -AT, 0.7±0.9 nonresp-AT, p=0.04). However, delta-BASDAI (ΔBASDAI) showed no difference between the two groups (2.3±2.3 resp-AT, 1.5±1.6 nonresp-AT, p=0.1).

Table 1. DEMOGRAPHIC CHARACTERISTICS

Population=181	Controls (n=155)	Cases (n=26)	p
Baseline			
Age	55.3±15	50±10.8	0,009
Sex (male)	104 (67%)	16 (62%)	0,6
B27+	93 (74%)	15 (62%)	0,3
BMI	25,5±5,3	28,7±5	0,013
Smokers	26	8	0,056
Disease duration (years)	9,5 ±12	7,6±9,3	0,4
RX (133): Sacroiliitis	65	14	0,6
MRI (37): Sacroiliitis	16	2	1
Uveitis	27	6	0,5
Enthesitis	53	16	0,015
Dactylitis	8	0	0,6
Peripheral	88	11	0,2
Psoriasis	16	5	
CRP baseline	16,7±23,7	12,3±21,3	0,4
ESR baseline	25,6±23,5	22±16	0,5
BASDAI baseline	5,6±2	6,1±1,9	0,2
ASDAS baseline	3,3±1,1	3,3±1,1	0,8
FAMES baseline	91	9	0,03
At 6 months			
BASDAI	3,2±2,3	4,7±2,4	0,004
ASDAS	1,7±0,9	2,7±1,2	0,00
ΔBASDAI	2,3±2,3	1,5±1,6	0,1
ΔASDAS	1,5±1,2	0,7±0,9	0,004
At drug discontinuation			
Monoterapia	51	16	0.08
Drug levels	138	13	0,02
ADA	1	4	0,00

24% of the nonresp-AT were ADA + at drug discontinuation, while only 0.7% of the AT-resp (AT) were ADA + (p=0.00) at last visit.

Conclusions: In our cohort of patients with axial SpA, a significant improvement in BASDAI, ASDAS and ΔASDAS after 6 months of treatment is associated with a lower frequency of drop-out of the first AT. Moreover a lower BMI, DMARDS at baseline and absence of ADA determine a better response to AT treatment.

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AB0715 DIFFERENCES IN THE CO-MORBIDITIES DESCRIBED FROM SPONDYLOARTHRITIS PATIENTS WITH OR WITHOUT CONCOMITANT FIBROMYALGIA

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Objectives: To assess the differences in the occurrence of co-morbidities from cardiovascular, respiratory, renal/urological and Central nervous systems (CNS) between patients with spondyloarthritis (SpA) not having headache as presenting symptom and those having headache assuming that those describing headache represent secondary (s) fibromyalgia (FM). (previous submitted abstract provides justification on headache as presenting symptom associated with secondary sFM).

Methods: Data obtained through a questionnaire from 776 patients seen in clinic with SpA was analysed with reference to headache as symptom at presentation. From the total 776 patients 13 patients did not record an answer to the question and were hence excluded. The remaining 763 patients were divided in 2 groups: Those having headache at presentation (n=117) considered having sFM, and those not having headache at presentation (n=656).

	Headache at presentation (n=117)	No headache at presentation (n=656)	Statistical significance (p)	CI
Age (mean ± SD)	47.7 (13.16)	48.3 (14.3)	0.1	-5.757 to 0.912
Gender (M:F) ratio	28:89 1:3.1	219:419 1:1.9	0.3	-0.025 to 0.077
Disease duration	11.4 (12.1)	10.9 (10.8)	0.4	-1.905 to 4.470
Delay in diagnosis	6.43 (8.9)	6.3 (8.1)	0.7	-3.151 to 2.151
ESR	15.5 (14.8)	18.2 (18)	0.07	-11.064 to 0.582
CRP	10.4 (36)	8.2 (9.8)	0.4	-6.106 to 12.536
BASDAI score	7.31 (3.7)	6.06 (2.08)	0.000 (<0.005)	0.783 to 2.624
BASFI score	5.6 (2.7)	5.04 (2.7)	0.09	-0.143 to 1.626
Main problem				
Fatigue	77/116 (66.4%)	340/608 (55.9%)	0.018	0.029 to 0.299
Pain with pressure	71/117 (61.2%)	257/807 (42.4%)	0.000	0.122 to 0.378
Co-morbidities				
Heart	16/100 (16%)	59/479 (12.3%)	0.002	0.44 to 0.196
Lungs	11/99 (11.1%)	52/475 (10.9%)	0.1	-.014 to 0.135
Dizziness	50 (104) 48.1%	147/408 (30.1%)	0.000	0.220 to 0.453
Numbness	58 (105) 55.2%	199/505 (39.4%)	0.000	0.188 to 0.441
Kidneys/urology	23 (102) 22.5%	100/479 (20.9%)	0.1	-0.31 to 0.188