previously reported[1]. Our patients showed low levels of SLEDAI/SLICC. There was not relation between activity levels and baseline damage with the presence of depression[4]. FACIT IV scale was a good independent predictor of fatigue in SLE patients with or without depression vs controls.

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**Disclosure of Interest:** None declared

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**FRI0277** **ANTI-SSA ANTIBODY STATUS IN COMBINATION WITH ULTRASOUND OF MAJOR SALIVARY GLANDS: A SHORTCUT IN THE CLASSIFICATION OF PRIMARY SJÖGREN'S SYNDROME?**

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**Background:** Ultrasound of major salivary glands (sUS) is an upcoming diagnostic method to assess the involvement of major salivary glands in primary Sjögren's syndrome (pSS). In the AECG, ACR and recently published ACR-EULAR criteria, a positive salivary gland biopsy and/or presence of anti-SSA antibodies are necessary to classify a patient as pSS, while sUS is not included as a diagnostic item.

**Objectives:** To assess whether combining anti-SSA antibody status with sUS outcome can predict classification of patients as pSS in our inception cohort study.

**Methods:** Consecutive outpatients clinically suspected with pSS underwent sUS of the parotid and submandibular glands. Parenchymal echogenicity, homogeneity, hypoechogenic areas, hyperechogenic reflections and clearness of salivary gland border were scored according to the Hocevar scoring system (total score 0–48).[1] Positive sUS was defined as total score $\geq$15. Patients underwent a diagnostic work up according to the AECG, ACR and ACR-EULAR criteria. We analyzed the predictive value of the combination of anti-SSA antibody status and sUS outcome for classification as pSS or non-pSS. Separate analyses were done considering either i) parotid gland biopsy or ii) labial gland biopsy as an item, when applying these classification criteria.

**Results:** Anti-SSA antibody status was positive in 53 (51%) patients and sUS was positive in 40 (39%) patients.

When parotid gland biopsy outcome was considered as an item of the criteria, 45 of 97 patients were classified as pSS according to the AECG, 44 of 97 according to the ACR and 52 of 99 according to the ACR-EULAR criteria. The combination of presence of anti-SSA antibodies with positive sUS showed a very high positive predictive value for classification as pSS (94–97%) and the combination of absence of anti-SSA antibodies with negative sUS highly excludes classification (negative predictive value 98–100%).

When labial gland biopsy outcome was considered as an item of the criteria, 49 of 96 patients were classified as pSS according to the AECG, 43 of 93 according to the ACR and 55 of 97 according to the ACR-EULAR criteria. The combination of presence of anti-SSA antibodies with positive sUS showed a high positive predictive value for classification as pSS (94–97%). However, the combination of absence of anti-SSA antibodies with negative sUS did not per se exclude classification (negative predictive value 89–93%).

**Conclusions:** In our prospective inception cohort study derived from daily clinical practice, the combination of presence of anti-SSA antibodies and positive sUS outcome highly predicts classification as pSS according to the AECG, ACR and ACR-EULAR classification criteria.

**References:**

[1] Hocevar et al. Rheumatology (Oxford) 2005;44:768–72.

**Disclosure of Interest:** None declared

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**FRI0278** **PREVALENCE OF PRIMARY SJÖGREN'S SYNDROME IN A POPULATION-BASED COHORT IN THE UNITED STATES**

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**Background:** Different studies worldwide reported highly discrepant estimates for the prevalence of primary Sjögren's syndrome (pSS), ranging from 0.01% of the general population to more than 3%. No previous study reported the prevalence of pSS in the United States.

**Objectives:** To report the 2015 point prevalence of pSS in the first population-based study performed in the U.S.

**Methods:** Cases of all potential pSS patients living in Olmsted County, Minnesota on January 1, 2015 were retrieved using the Rochester Epidemiology Project resources, and ascertained by manual medical record review. Definite pSS cases were defined according to physician diagnosis. All patients with doubtful cases and all patients with an associated systemic autoimmune disease were excluded. The use of diagnostic tests was assessed and the performance of classification criteria in this community-based cohort was evaluated. The number of prevalent cases in 2015 was also projected based on 1976–2005 incidence data from the same source population.

**Results:** A total of 106 patients with pSS were included in the study: 86% were female, with a mean (SD) age of 64.6 (15.2) years and disease duration of 10.5 (8.4) years. A majority were anti-SSA positive (75%) and/or anti-SSB positive (58%), but only 22% met American-European Consensus Group or American College of Rheumatology criteria because the other tests required for disease classification were rarely performed in clinical practice (ocular dryness objective assessment, salivary gland functional or morphologic tests, or salivary gland biopsy). According to the physician diagnosis, age and sex adjusted prevalence of pSS was 10.3/10,000 inhabitants, but according to classification criteria this prevalence would be only 2.2/10,000. The analysis based on previous incidence data projected a similar 2015 prevalence rate of 11.0/10,000. Using figures from the 2015 general U.S. population census, a total of 248,000 patients with pSS (35,000 males and 213,000 females) would currently live in the country. If only cases fulfilling classification criteria are considered, there would be only about 53,000 prevalent cases of pSS in the U.S.

**Conclusions:** This study reports the first prevalence rate of physician-diagnosed pSS in a well-defined population in the U.S. The estimated prevalence of 10.3/10,000 inhabitants in 2015 is higher than previous results obtained in other geographical areas, probably due to different methodological designs of the studies. Because physicians rarely used tests included in the classification criteria to diagnose the disease in this community setting, current classification criteria do not reflect accurately the diagnosis of pSS in routine clinical practice.

**Disclosure of Interest:** None declared

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**FRI0279** **PREVALENCE AND FACTORS ASSOCIATED WITH PRECONCEPTIONAL COUNSELING IN WOMEN WITH AUTOIMMUNE RHEUMATIC DISEASES**

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**Background:** Adequate prenatal counseling in women with autoimmune rheumatic diseases (ARDs) may help minimize maternal-fetal complications. However, the available information about the frequency and quality of prenatal counseling given to these patients is limited.

**Objectives:** To estimate the prevalence of preconceptional counseling and associated factors in women with ARDs.

**Methods:** A survey was conducted on socio-demographic data, gynecological-obstetric history, and domains related to preconception counseling in women with ARDs at the reproductive stage. It was defined as adequate preconception counseling if the patient knew that the pregnancy should be medically planned, that the complications are associated with severity/activity of the disease, that they should use an effective contraceptive method and that their medications may or may not be used during pregnancy. Descriptive statistics, Student's T test for quantitative variables with normal distribution, Mann-Whitney U test for non-normal and chi-square distribution were used for categorical or ordinal variables.

**Results:** Of a total of 146 surveys, 131 were analyzed. Only 49 (37.4%) patients received adequate preconception counseling. Two thirds of the patients had systemic lupus erythematosus (Table). The time of evolution of the disease was a factor associated with receiving adequate counseling (5.6 vs 3.6 years, p=0.023). Illness, marital status, and level of education were not factors associated with

| | Adequate Counseling (n=49) | Inadequate counseling (n=82) | P value |
|---|---|---|---|
| Age (years) [a] | 30.8±7.0 | 30.5±8.5 | 0.836 |
| Time of evolution (years)[b] | 5.6 (0.25–29) | 3.6 (0.25–27) | 0.023 |
| Previous pregnancies[b] | 1 (0–4) | 1 (0–5) | 0.192 |
| Rheumatoid arthritis[c] | 13 (26.5%) | 18 (22%) | 0.69 |
| Systemic lupus erythematosus[c] | 31 (63.3%) | 52 (63.4%) | |
| Use of contraceptive method[c] | 31 (63.3%) | 44 (53.7%) | 0.282 |
| Use of embryotoxic/teratogenic drugs[c] | 39 (79.6%) | 34 (41.5%) | 0.001 |
| Counseling for a rheumatologist[c] | 37 (75.5%) | 28 (34.1%) | 0.001 |
| Counseling by other doctors[c] | 35 (24.5%) | 31 (65.9%) | 0.197 |
| Professional education[c] | 23 (46.9%) | 31 (37.8%) | 0.616 |
| Married[c] | 15 (30.6%) | 32 (39%) | 0.774 |

[a]Student's t-test; [b]U of Mann Whitney; [c]Chi square.