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AB0711 REVIEW OF MANAGEMENT OF HLA B27 POSITIVE UVEITIS PATIENT ATTENDING A TERTIARY HOSPITAL – HOW GOOD ARE WE?

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Background: Delay in diagnosing Spondyloarthritis is well documented. One of the reasons for the delay is the presentation of these group of patients to different specialties due to variety of extra articular manifestations. Acute anterior uveitis (AAU) is the most common extra-articular manifestation in HLA B27 positive spondyloarthropathies, occurring in 30–50% of cases [1]. It can occur before the onset of rheumatologic symptoms [2,3]. However quite often this group of patients is not routinely referred to or seen by the rheumatologist for further evaluation.

Objectives:

- To assess the ophthalmologist practice in evaluating patients with AAU for inflammatory back pain or other Rheumatological diagnoses.
- To identify the number of HLA B27 requests made for uveitis patients.
- To identify the referral rate of HLA B27 uveitis patients to Rheumatologists for evaluation.

Methods: We conducted a retrospective pilot study to assess all patients with AAU presenting over a period of one-week to our busy teaching hospital eye casualty which serves over one million population. All patients with Iritis were identified from eye casualty records and medical case notes were obtained. A standard proforma was designed and piloted with few case notes initially. Modified proforma was subsequently used to collect the data which was collated and analysed using EXCEL spreadsheet.

Results: A total of 62 patients (n=62) with AAU presented to eye casualty over a one-week period. Case notes of 49 patients could be procured. Majority of the patients were Caucasians (n=35) while the rest were Asians (n=12) and blacks (n=2). Sex ratio was nearly equal with 25 patients being males and the rest females. Most of our patients' age ranged between 20 to 60 years. 60% patients had a history of recurrent iritis. Out of these 9 patients had bilateral uveitis and 14 were unilateral. In 6 patients, the laterality was not documented. A history for spondyloarthropathy was elicited in only 14 patients by the ophthalmologist at the time of initial assessment. Out of these 14 patients Inflammatory back pain history was positive in 10 patients. Only 17 out of 62 (27%) patients had HLA B27 checked and it was noted to be positive in 5. Amongst the 5 HLA B27 positive patients 2 patients were referred to rheumatology whereas 2 patients were already under rheumatology.

Conclusions: We observed that there is a clear lack of understanding in eliciting effective rheumatology history in patients with recurrent anterior uveitis and requesting HLA B27 appropriately. Therefore, a need for a clear pathway for managing patient presenting with recurrent uveitis and HLA B27 positivity for evaluation of Inflammatory back pain. Clear local guidelines and pathway need to be developed to provide effective care. Good communication between the Ophthalmologist and Rheumatologist is key in early diagnosis and effective management of this deforming condition.

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AB0712 CLINICAL CHARACTERISTICS OF SPONDYLARTHROSIS (SPA) WITH AND WITHOUT PERIPHERAL ENTHESITIS – DATA FROM THE DESIR COHORT

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Background: Peripheral enthesitis, mostly in the lower limbs, is a major feature of spondyloarthritis (SpA). Its prevalence is highly variable depending on the population studied, estimated between 10% and 70%. The probability to develop a peripheral enthesitis over time and the factors associated with it are mostly unknown.

Objectives: The aims of the present study were: 1) To describe the prevalence

and characteristics of peripheral enthesitis in early axial SpA population, at the inclusion in the DESIR cohort; 2) to estimate the incidence of peripheral enthesitis over time; 3) to determine the factors associated with the presence of peripheral enthesitis.

Methods: We used data from the DESIR cohort, a prospective multi-center, longitudinal French cohort of 708 patients with inflammatory back pain suggestive of early axial SpA (<3 years since axial symptoms onset). We performed a descriptive analysis to evaluate the prevalence and characteristics of the peripheral enthesitis at time of inclusion (location, number of enthesitis, and mean time between first enthesitis and axial symptoms). We also estimated the incidence of peripheral enthesitis over a follow up period of 60 months, using Kaplan-Meier curves. Finally, we determined the baseline characteristics associated with the presence of a peripheral enthesitis by multivariable analysis (logistic regression, including the variables significantly associated in the univariable analysis).

Results: At inclusion, 395 patients (55.8%) had peripheral enthesitis in their past medical history. The locations were mainly the plantar fascia (212/395, 53.7%) and the Achilles tendon (152/395, 38.5%). Seventy-seven (19.4%) of these patients developed peripheral enthesitis before their axial symptoms, with a mean time interval of 773 days. During the 5-year follow-up period, 109/708 (15.4%) patients developed new peripheral enthesitic symptoms, resulting in 504/708 (71.2%) patients who had presented with at least one episode of peripheral enthesitis at 5 years. Variables associated to peripheral enthesitis according to the univariable analysis were: older age, male gender, HLA B27 positivity, MRI sacroiliitis, Modified NY criteria fulfilled, presence of either anterior chest wall pain, peripheral arthritis, dactylitis or psoriasis, high BASDAI, BASFI or mean score ASAS-NSAID. Only the history of anterior chest wall pain and of peripheral arthritis were significantly and independently associated with the presence of peripheral enthesitis in the multivariable analysis (Odds Ratio (OR) =1.6 [95% Confidence interval (1.6 [1.1–2.3], and OR=2.1 [1.4–3.0], respectively)

Conclusions: This prospective study highlights the high prevalence of peripheral enthesitis in early axial SpA and stresses the importance of researching any signs and symptoms of enthesitis, especially in those patients with anterior chest wall pain and peripheral arthritis.

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AB0713 UVEITIS SECONDARY TO SPONDYLARTHROSIS IN AN OCULAR INFLAMMATION INTERDISCIPLINARY UNIT

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Objectives: To describe the characteristics of ocular involvement in spondyloarthritis in an ocular inflammation interdisciplinary unit.

Methods: This descriptive study include the patients with uveitis secondary to spondyloarthritis or inflammatory bowel disease (IBD) treated by the rheumatologist from January 2012 to December 2016 in an ocular inflammation multidisciplinary unit. Demographic characteristics, aetiology, ocular involvement pattern, and systemic therapy data were collected and analysed.

Results: From 276 patients evaluated by the rheumatologist, 111 (40.2%) were uveitis secondary to systemic inflammatory diseases. Within this group, the uveitis

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 chronic 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. Nowadays 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 analyzed 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	0.783 to 2.624
			(<0.005)	
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	-0.14 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