AB0873 CHARACTERISTICS OF ADHERENCE, PERSISTENCE AND THERAPEUTIC ALLIANCE IN PATIENTS WITH GOUT

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Background: Adherence is the extent to which the patient takes their medications and follow the directions prescribed by their doctor. It has two components: compliance (the degree or extent of conformity to the recommendations about day-to-day treatment by the provider with respect to the timing, dosage, and frequency) and persistence (the duration of time from initiation to discontinuation of therapy). The therapeutic alliance is the patient physician relationship that allows the patient to participate actively in their treatment. The reported adherence varies from 43 to 78% in patients with chronic diseases. In gout, the adherence varies from 10 to 46%.
Objectives: To evaluate the characteristics of adhesion in patients with gout.
Methods: Patients with gout from the GRESGO cohort were included. Sociodemographic, clinical, and treatment data were collected and the HAQ-DI, EuroQol-5d and a specific questionnaire of adherence and therapeutic alliance were applied.
Results: The study included 238 patients (97.1% male), whit a mean age of 47.7±12.7 years, educational level 9.2±4.2 years. The adherence index (prescribed doses/doses taken) was 86%. Only 28.6% never stopped treatment. 4.6% took the doses at the correct time. Most frequent causes of suspension were lack of supply (37%) and forgetfulness (30%). Only 5% buy all of their medications, 10% follow the lifestyle changes. 49.6% do not take the medication when they disagree with their doctor.
Conclusions: Despite having a good adherence index there are discrepancies with the qualitative answers, since more than 70% did not have good persistence and more than 90% did not comply with the schedule.
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AB0874 CHARACTERISTICS OF GOUT IN CAMEROON, CENTRAL AFRICA: A HOSPITAL-BASED STUDY

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Background: Few data are available on the characteristics of gout in sub-Saharan Africa (1).
Objectives: We performed this study with the aim to present the clinical, laboratory and imaging characteristics of gout at the time of diagnosis in Cameroon.
The results obtained will be compared with data from the Western literature.
Methods: We performed a cross-sectional study among the 10,186 out patients seen at the Rheumatology unit of Douala General Hospital, Douala, Cameroon, between 2004 and 2014. We included patients with gout diagnosis (ACR criteria 1977). The main socio-demographic and clinical data on gout at the time of diagnosis were collected.
A p<0.05 was significant.
Results: We included 511 patients (5.02%) including 415 men and 96 women. The mean age was 55.9±10.8 years.
Joint pain (n=508, 99.4%), joint effusion (n=198, 38.7%) and fever (n=20, 3.9%) were the main reasons for consultation at diagnosis. Knees (n=300, 62.6), ankles (n=187, 39.0%) and MTP1 joints (n=128, 26.7%) were the most affected joints. Tophi were mainly located at the elbows (n=72, 66.0%), MTP1 (n=20, 18.3%), and ears (n=18, 16.5%) [Table 1].
Gout was as acute (n=255, 49.9%) as it was chronic (n=256, 50.1%). The clinical presentation was oligoarticular in 195 patients (38.7%), monoarticular in 172 patients (34.1%), and polyarticular in 137 patients (27.2%).
The mean uric acid level was 82.4±22.3 mg/L, with hyperuricemia found in 401 patients (78.4%). Elevated acute phase reactants was present in 81.9% of patients. Structural involvements related to gout were present in 181 (74.8%) of the 241 patients who had performed an X-ray.
Comorbidities were present in 344 patients (67.3%), hypertension (n=208, 40.7%), obesity (n=151, 29.5%), osteoarthritis (n=111, 21.7%), oesogastroduodenal

Table 1. Localization of gouty arthritis and tophi

Joint stiffness and/or tenderness		Tophi location	
	n (%)		n (%)
Knee	300 (62.6)	Elbow	72 (66.0)
Ankle	187 (39.0)	MTP1	20 (18.3)
MTP1	128 (26.7)	Ear	18 (16.5)
Wrist	93 (19.4)	Wrist	10 (9.2)
Elbow	81 (16.9)	PIP	9 (8.2)
PIP	56 (11.7)	Foot	9 (8.2)
MCP	53 (11.1)	IDP	8 (7.3)
Foot	50 (10.4)	Ankle	8 (7.3)
Shoulder	49 (10.2)	Knee	8 (7.3)
Others MTP	24 (5.0)	Others MTP	6 (5.5)
DIP	15 (3.1)	MCP	5 (4.6)
Others	30 (6.3)	Achille tendon	1 (0.9)
		Imprecises location	18 (16.5)

complaints (n=74, 14.5%), diabetes (n=52, 10.2%), and chronic kidney diseases (n=42.8.2%).
Associated factors (p<0.05) in the occurrence of gout were obesity, alcohol intake, diuretics intake, and menopause (in women).
Conclusions: Gout has the same clinical, laboratory and imaging characteristics in Cameroon than in Western countries. The main difference comes from the place of the knee as the main joint involved by gouty arthritis at the time of diagnosis in our study.
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AB0875 DO WE CONTROL GOUT IN PRIMARY CARE FOLLOWING EULAR RECOMMENDATIONS?

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Background: Inadequate control of hyperuricaemia in gout patients can lead to more arthritis, activity limitations and higher gout-related treatment costs. General Practitioners can use well tolerated urate-lowering drugs, but some patients are inadequately controlled. European League against Rheumatism (EULAR) has published new guidelines[1] in 2016 with similar serum Uric Acid (sUA) goals.
Objectives: To evaluate sUA control in patients diagnosed with gout who were attended in primary care and to compare them to EULAR 2016 guidelines[1].
Methods: Retrospective analysis, carried out in 2 primary care health centres (8 family doctors) in Spain. We selected patients that have consulted in the last year diagnosed with gout at any time. Demographic variables, gout-related drugs and last sUA level were collected. Adequate control was defined as sUA level <6 mg/dL.
Limitations: We used only one isolated sUA value. No drug doses were analyzed. We did not distinguish severe from mild gout.
Ethical-legal aspects: We did not identify the patients. There was no intervention.
Results: We analyzed 231 patients diagnosed with gout, mean 70.1 years-old (Confidence Interval $CI_{95\%}$ 68.3–72.0), 189 (81.8%) were men. The mean sUA was 6.55 mg/dL ($CI_{95\%}$ 6.31–6.79 mg/dL).
39% were adequately controlled according to EULAR (sUA <6 mg/dL), 25.5% were close to the objective (6–7mg/dL) and clearly inadequate (>7mg/dL) in 35.5%. 10% had really bad control (sUA >9 mg/dL).
There was no difference between control in male 6.58 mg/dL ($IC_{95\%}$ 6.33–6.83) and female 6.40 mg/dL ($CI_{95\%}$ 5.73–7.07). Control improves in elder people: <60 years 7.01 mg/dL ($CI_{95\%}$ 6.60–7.42) vs.>70 years 6.30 mg/dL ($CI_{95\%}$ 6.00–6.60) The only 14 patients receiving febuxostat achieved similar control using allopurinol (6.5 versus 6.7 mg/dL).
Conclusions: The degree of control of sUA in primary care patients in our area is mostly between optimal and acceptable, but it can be optimized in more than half of the cases. In a few patients the control is lousy. The worst-controlled patients were the youngest.
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AB0876 OSTEOMALACIA: MODALITIES OF PRESENTATION AND ETIOLOGY OF 20 CASES

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Background: Osteomalacia is a defect of mineralization of the protein framework of the skeleton.
Objectives: We try through our series to determine the presentation modalities and the various causes of this fragile benign osteopathy.
Methods: It is a descriptive retrospective study of cases collected in our rheumatology department between 2001 and 2016, concerning patients with osteomalacia
Results: Twenty patients were collected: 13 women and 7 men with an average age of 53±19 years [22 years, 80 years]. The mean duration of the disease is 45 months [5–172]. The findings were: bone pain in 55% of cases, pelvic pain in 45% of cases, a waddling gait in 5 cases (25%), fractures with low energy in 40% of cases, Functional impotence of the lower limbs in 35% of cases and a biological discovery in 2 cases (10%). Hypocalcemia, phosphorus deficiency and hypocalciuria were found in 14 cases, ie 70%. Alkaline phosphatases were elevated in 12 cases, with a variable rate of 2 to 7 times normal.The PTH, performed in 17 cases, was elevated in 53% of the cases. In our series, all