In the bivariate analysis, factors statistically significant associated with the development of DKF were: glomerular sclerosis, fibrous crescents, interstitial cell infiltration and tubular atrophy; having membranous component resulted as a "protector" factor for the development of DKF. The Cox regression model included all the factors with a p-value less than 0.25 in the bivariate analysis; independent factors associated with increased HR of DKF were glomerular sclerosis and fibrous crescents; however, hyaline thrombi and presence of membranous nephritis were associated with a decreased HR of DKF. (Table 1).

Conclusions: We describe factors associated with a DKF. We found that the proliferative LN in combination with membranous have a better prognosis than pure proliferative LN. Our study could help to evaluate the effects of therapies in LN.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.4156

FRI0715 BEING A WOMAN AND HAVING KNEE OSTEOARTHRITIS INCREASES THE LIKELIHOOD OF COMORBIDITIES

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Background: Osteoarthritis (OA) is the most prevalent joint disease and the leading cause of disability from 60 years onwards. In fact, 14.8% of the Spanish population has OA.

Objectives: This study aimed to determine if there is a differential profile and greater comorbidity in women affected by symptomatic knee OA compared to a control group without OA.

Methods: The EMARTRO study was designed as an observational, multicenter, transversal study to compare probability of suffering a comorbidities based on presence of symptomatic knee OA visited by GPs. Sociodemographic, anthropometric, clinical parameters and clinical variables of interest were recorded. The probability of suffering comorbidities in each study group was estimated using the Odds Ratio estimation with conditioned logistic regression models. The HAD scale, the Goldberg health questionnaire were administered to patients and the concomitant medication was also registered. The comparison between groups was done using t-Student, Chi-square and Mann-Whitney.

Results: A total of 897 women were included with a mean (SD) age of 67.4 (6.8) years.

Osteoarthritic women were obese and had a higher BMI compared with control group, 31.2 (5.5) vs 27.5 (4.3) ($p < 0.0001$), respectively. Regarding blood pressure, no differences were found in the systolic BP ($p = 0.0646$) but in the diastolic, women with OA also had higher values, 77.9 (9.1) vs 75.8 (8.9) mmHg ($p = 0.0005$).

In general terms, the presence of OA doubled the probability of having concomitant conditions with respect to controls [OR=2.220 (95% CI: 1.449–3.400) $p = 0.0002$]. Likewise, women with symptomatic knee OA were more likely to have hypertension [OR=1.697 (95% CI 1.299–2.217), $p = 0.0001$], venous peripheral vascular disease [OR=2.148 (95% CI 1.547–2.984), $p < 0.0001$] and gastroesophageal reflux (OR=1.890 (95% CI 1.297–2.754), $p = 0.0009$).

Regarding the mental health of the patients, according to the Goldberg scale, 41% of the patients with OA elicited psychopathology vs 17.8% in controls, $p < 0.0001$. As for the HAD scale, there were more cases of anxiety ($p < 0.0001$) and depression in the OA women ($p < 0.0001$).

The greater burden of physical and mental comorbidity in the OA patients was accompanied by a higher consumption of concomitant medications ($p < 0.0001$).

Conclusions: The results of the present study indicate that in patients with knee OA, being female is a risk factor for the development of concomitant pathologies. Also, the increased likelihood of suffering from hypertension, venous peripheral vascular disease and gastroesophageal reflux should determine chronic medications for the treatment of osteoarthritis.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3494

FRI0716 RISK STRATIFICATION IN YOUNG PATIENTS WITH ACUTE MYOCARDIAL INFARCTION USING THE ADJUSTED GLOBAL ANTIPHOSPHOLIPID SYNDROME SCORE (AGAPSS)

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Background: Young adults with acute myocardial infarction are a critical group to examine for the purpose of risk factors stratification and modification [1].

In the setting of underlying systemic autoimmune diseases, premature cardiovascular disease deserves even more attention in these conditions, such as antiphospholipid syndrome (APS), the most common acquired thrombophilia.

Objectives: In this study we aimed to assess the clinical utility of the adjusted Global Antiphospholipid Syndrome Score (aGAPSS)[2] for the risk stratification of acute myocardial infarction in a cohort of young APS patients with thrombotic events.

Methods: The analysis included 83 consecutive APS patients (≤ 50 years old) who presented with arterial or venous thromboembolic events. Data on cardiovascular risk factors and antiphospholipid antibodies (aPL) positivity were retrospectively collected. The aGAPSS was calculated for each patient by adding the points corresponding to the risk factors, based on a linear transformation derived from the β regression coefficient as follows: 3 for hyperlipidaemia, 1 for arterial hypertension, 5 for aCL IgG/IgM, 4 for anti-b2 glycoprotein I IgG/IgM and 4 for LA.

Results: Demographic, clinical and laboratory characteristics of the cohort are summarized in Table 1. Higher aGAPSS values were observed in patients with acute myocardial infarction when compared to the others [mean aGAPSS 11.9 (S.D. 4.15, range 4–18) Vs. (mean aGAPSS 9.2, S.D. 5.1, range 1–17); T test: $p < 0.05$]. Significantly higher aGAPSS values were also seen in patients with acute coronary syndrome compared to patients with a history of peripheral or cerebrovascular arterial thrombotic events [mean aGAPSS 11.9 (S.D. 4.15, range 4–18) Vs. (mean aGAPSS 6.7, S.D. 5.7, range 1–17); T test: $P < 0.005$]. When separating for cardiovascular risk factors and aPL positivity, hypercholesterolemia was significantly higher in the group that developed myocardial infarction compared with patients with a history of any thrombosis and patients with a history of peripheral or cerebrovascular arterial thrombotic events (Chi square test: $p < 0.0001$ and $p < 0.0001$) and significantly higher rate of multiple positivity

Patients Characteristics	All (n=83)	%
Female sex	75	90
Age, mean (S.D.), years	44.6 (11.3)	
Disease duration, mean (S.D.), years	11.4 (7.8)	
Caucasians, n	82	93
Arterial thrombosis, n	53	60
Venous thrombosis, n	44	50
Acute Myocardial infarction	13	15
PAPs, n	31	35
SLE and APS, n	44	50
Arterial Hypertension, n	27	31
Hyperlipidemia, n	16	18
LA, n	38	43
aCL IgG/IgM, n	65	74
IgG	60	68
IgM	35	40
Anti-beta2GPI IgG/IgM, n	44	50
IgG	39	44
IgM	12	14
Triple aPL positive	27	31

Table 1. Demographic, clinical and laboratory characteristics of the cohort

	Acute myocardial infarction (13)	Arterial and/or venous thrombosis (70)
Hyperlipidemia	10	9
Arterial Hypertension	4	22
LA	8	31
aCL IgG/IgM	11/6	51/30
Anti-beta2GPI IgG/IgM	8/2	31/11
Triple aPL positive	5	22

Table 2. Patients cardiovascular risk factors and aPL positivity between groups

for LA, aCL (IgG/IgM), anti- β 2GPI antibodies (IgG/IgM) were present in the group that developed myocardial infarction (Chi square test: $p < 0.05$ for all aPL) (Table 2).

Conclusions: The aGAPSS is based upon a quantitative score and could aid risk stratifying APS patients younger than 50 years for the likelihood of developing coronary thrombotic events and may consequently guide pharmacological treatment for high-risk patients.

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Acknowledgements: None.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.1600

FRI0717 POSITIVE CONVERSION OF TUBERCULOSIS SCREENING RESULTS AND INCIDENCE OF ACTIVE TUBERCULOSIS INFECTION IN PATIENTS RECEIVING BIOLOGIC TREATMENT

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Background: Previous studies reported active tuberculosis infections can occur during biologic treatment in patients with negative baseline LTBI screening. Current recommendations suggesting the annual testing for latent tuberculosis infections are mainly issued for patients with rheumatoid arthritis (RA) receiving anti-TNF inhibitors and there are lacking evidence for patients receiving non-TNF biologic agents and for patients with ankylosing spondylitis (AS) or psoriatic arthritis (PsA).

Objectives: This study was performed to investigate the conversion rate of initially negative tuberculosis screening test results during biologic treatment and the usefulness of repeated screening test for detecting unexpected tuberculosis infection in patients with RA, AS, and PsA.

Methods: A total of 95 patients (43 with RA, 50 with AS, and 2 with PsA) who had negative baseline interferon γ releasing assay (IGRA) results, which were assessed using QuantiFERON-TB Gold in tube (QTF-GIT), prior to initiation of biologic treatment were enrolled in this study. All patients received biologic agents for the treatment of their diseases and rescreening with QTF-GIT were performed in all patients after median 12 months from baseline test. Clinical characteristics were compared between converters and non-converters and incidence of active tuberculosis infection was evaluated.

Results: Patients were treated with different biologics (23 with etanercept, 50 with adalimumab, 5 with infliximab, 4 with golimumab, 1 with certolizumab pegol, 3 with abatacept, and 9 with tocilizumab). Positive conversions of initially negative IGRA were found in 13 (6 patients with etanercept, 4 patients with adalimumab, 2 patients with tocilizumab and 1 patient with abatacept) of 95 patients (13.7%) after initiation of biologic treatment. Age over 50 years and diagnosis of RA were more common in converters. Multivariate analysis showed that age over 50 was an independent risk factor for IGRA conversion with OR 4.36 (95% CI 1.10 - 17.34, $p=0.036$). During biologic treatments, active tuberculous infections were found in 3 of 13 converters (23.1%).

Conclusions: Although initial screening test showed negative results, the serial follow-up of tuberculosis screening test should be considered during biologic treatment in patients with rheumatic diseases to prevent unexpected tuberculosis infection.

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Acknowledgements: This study was supported by a grant of the Korean Health Technology R&D Project, Ministry for Health and Welfare, Republic of Korea (H14C1774).

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.1286

FRI0718 PREVALENCE AND PATTERN OF COMORBIDITIES IN CHRONIC RHEUMATIC AND MUSCULOSKELETAL DISEASES: THE COMORD STUDY

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Background: Rheumatic and musculoskeletal diseases (RMD) frequently coexist with other conditions, resulting in multimorbidity, which may compromise arthritis management and lead to diminished quality-of-life and increased mortality. In 2016, EULAR published "Points to consider for reporting, screening for and preventing selected comorbidities in chronic inflammatory rheumatic diseases", used to guide this study.

Objectives: The primary objective is to evaluate the prevalence and pattern of comorbidities in selected RMD in Lebanese patients. The secondary objective is to evaluate the gap between recommendations and routine comorbidities' screening.

Methods: COMORD is an observational, cross-sectional, multicentric national study. Consecutive RMD patients (Rheumatoid Arthritis (RA), Osteoarthritis (OA), Systemic Lupus Erythematosus (SLE), Axial Spondyloarthritis (AxSpA) and Peripheral Spondyloarthritis (pSpA)) as diagnosed by the rheumatologist were recruited at 6 practices from university hospitals and private clinics in Lebanon. Six axes of comorbidities (Cardiovascular, Malignancies, Infections, Gastrointestinal, Osteoporosis, Depression) were investigated using a case report form (patient interview). Optimal comorbidities screening was defined according to current recommendations and compared with monitoring in practice. Prevalences were presented descriptively. The number of comorbidities was correlated with predictive factors using Poisson Regression. Finally, Latent Class Analysis (LCA) was used to identify patterns of multimorbidity. All analysis were performed on IBM SPSS Statistics 23 and XLSTAT 18.07.

Results: 515 patients were recruited (196 RA, 161 OA, 75 AxSpA, 45 SLE, 40 pSpA). Mean age was 56y, 76% were female. There was no difference in the disease distribution between centers. The most common comorbidities were cardiovascular risk factors and diseases, followed by depression and osteoporosis. The number of comorbidities was significantly associated with age ($p < 0.001$), obesity ($p < 0.001$) and biotherapies ($p < 0.05$). LCA analysis identified 3 main clusters of multimorbidity: OA, RA, AxSpA (Fig 1). The most optimal screening was found for cardiovascular risk factors (84%). DXA was prescribed in 69% of correct indications. As for malignancies, mammograms and pap smears were the most optimally prescribed (36% and 28%). Colonoscopy and dermatology visit were prescribed in 22% and 18%. Correct vaccination (influenza and pneumococcal) was found in 17% and 8%. Predictive factors for optimal screening were age, university setting, social coverage, disease duration and biotherapy.

Figure 1. Identified Multimorbidity Clusters by Latent Class Analysis

Conclusions: Comorbidities are prevalent in RMDs and follow specific multimorbidity patterns, with a predominance for cardiovascular, depression and osteoporosis. They are more frequent with age and obesity. Optimal screening needs to be improved.

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