for LA, aCL (IgG/IgM), anti-β2GPI 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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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 QuatiFERON-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 tocillizumab and 1 patient with abatacept) of 95 patents (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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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 Erythematous (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 pSA). 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.

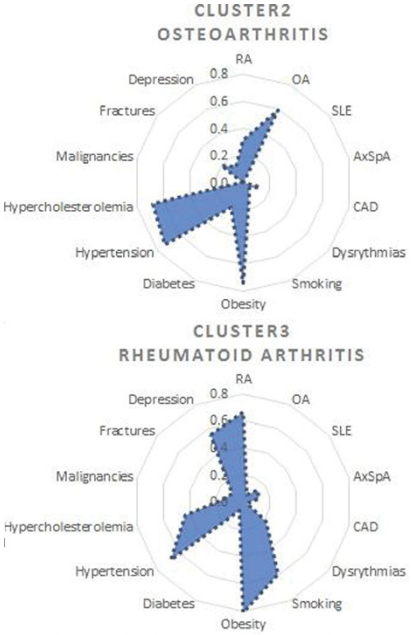

Figure 1. Identified Multimorbidity Clusters by Latent Class Analysis

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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