and 120 had anti-citrullinated peptide (anti-ccp) positive. Erosions were present in 106 RA patients. The prevalence of neoplasms was similar in RA and non-RA groups (n=24 *vs* 23, p=0,8) and 5 of the deads occurred in the RA-neoplasm group were due to the cancer. Of the 24 neoplasms in RA group, 9 appeared after the RA diagnosis was established (mean 10 years) and 17 before (mean 9,65 years). In RA patients correlation was found between male sex and neoplasm (p=0,04) as well as absence of RF rheumatoid factor and neoplasm (p=0,049). No correlation was found between the presence of neoplasm and anti ccp presence or erosions (p=0,3 and p=0,51 respectively). In this study, the overall risk of neoplasms in patients with RA was not associated with conventional or biological DMARD's. No differences were found between the type of tumour in RA patients *vs* non-RA, except for colon cancer, more prevalent in RA patients (p=0,03). Only 21 non-RA patients vs 19 RA patients were smokers and for so, it wasn't possible to establish any correlations.

Conclusions: In this study we found a prevalence of colon cancer in RA patients, as was found in other studies whoever, the increased risk for lung cancer and lymphoma often reported, was not found. It seems that male sex and the absence of rheumatoid factor are responsible for an increased risk. However we have several limitations: a very small sample, the population of the study was predominately Caucasian. Further studies examining specific aspects such as treatments, smoking or other lifestyle factors are needed to investigate the underlying mechanisms for the increased or decreased risk of specific cancers observed in patients with RA compared with the general population.

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AB0335 ARE EULAR RHEUMATOID ARTHRITIS (RA) MANAGEMENT RECOMMENDATIONS APPLICABLE AT THE COUNTRY LEVEL? SIMILARITIES AND DIFFERENCES WITH THE RECENT FRENCH RA MANAGEMENT RECOMMENDATIONS

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Background: Recently, EULAR updated the rheumatoid arthritis (RA) management recommendations.[1] [2] In 2018, the French Society of Rheumatology (SFR) updated their recommendations regarding the management of RA.[3] This gave us the opportunity to compare the recommendations.

Objectives: To update the 2014 French recommendations for the management of RA and to compare them to the EULAR recommendations.

Methods: The SFR approach was based on the literature and on expert opinion. A systematic literature review (SLR) was performed by 2 fellows, collecting data to answer 11 questions. The previous (2014) recommendations were updated by a committee including 11 rheumatologists, 2 patients and 1 healthcare professional, during a 1 day meeting in January 2018. The recommendations were compared to the recently issued EULAR recommendations.[1] [2]

Results: The SLR included 137 papers. The consensus process led to 4 overarching principles and 15 recommendations. The overarching principles emphasise the need for shared decisions between the rheumatologists and the patient and the importance of a global approach of RA including pharmaceutical and non-pharmacological management. The recommendations address the diagnostic phase of RA, early initiation of disease-modifying antirheumatic drugs (DMARDs) and the usefulness of regular disease activity assessments through validated composite indices with a target of clinical remission or low disease activity. As first strategy, the expert committee recommends methotrexate (MTX). In case of intolerance or inadequate response to MTX, treatment must be optimised. If unfavourable prognostic markers are present, adding a targeted treatment (either biologic or synthetic) can be proposed, at best in combination with MTX; if not, switching to another conventional synthetic DMARD (csDMARD) or combined csDMARDs therapy can be proposed. While waiting for csDMARDs efficacy, short term (less than 6 months) glucocorticoids (GC) can be proposed. Second-line and further treatments and management of remission are also addressed, as well as the importance of managing comorbidities and of non-pharmacological measures.

Conclusions: These recommendations are designed to improve the management of RA and are concordant with the recent EULAR recommendations on several items. Main differences concern the place of GC and of combined csDMARD therapy, as well as additional points on diagnosis, non-pharmacological measures, comorbidities and the importance of a global approach.

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AB0336 HEPATITIS B VIRUS REACTIVATION IN RHEUMATOID ARTHRITIS PATIENTS WITH HBSAG-NEGATIVE/ANTI-HBC-POSITIVE STATUS

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Background: Hepatitis B virus (HBV) reactivation in rheumatoid arthritis (RA) patients with positive hepatitis B surface antigen (HBsAg+) is one of the treatment-related complications. The risk of reactivation in patients with negative hepatitis B surface antigen but positive anti-hepatitis B core antibody (HBsAg+/anti-HBc-) is less well defined compared to their HBsAg +counterparts.

Objectives: This retrospective, single centre study aimed to study the prevalence of HBV reactivation (defined as HBV DNA becoming detectable) among RA patients with HBsAg+/anti-HBc +status, and to investigate any factors predicting reactivation.

Methods: RA patients attending the rheumatology specialist clinic in a local tertiary hospital between 1st January 2011 and 31st December 2016 were included if they had of[1] HBsAg-/anti-HBc +status and[2] undetectable HBV DNA at baseline. Demographic data, clinical parameters including treatments for RA and any use of antiviral prophylaxis, and laboratory results including anti-hepatitis B surface antibody (anti-HBs) and serial HBV DNA levels were obtained. Chi-square (or Fisher exact test if number was less than 5) was used for analysis of categorical variables. Student's t-test and Mann Whitney test were used for analysis of parametric and non-parametric continuous variables respectively.

Results: Majority (80%) of the 107 included patients included were female and the mean age was 62.5-year-old (SD 12.09). All the patients were receiving disease modifying anti-rheumatic durgs (DMARDs), 43% of which (n=46) were on biological therapy (with or without concomitant synthetic DMARDs) and the remaining (n=61) were only on conventional synthetic DMARDs (8 on monotherapy, 53 on combination therapy). As antiviral prophylaxis was not mandatory in HBsAg-/anti-HBc +patients according to local guideline, only 13 patients (12.1%) were on antiviral cover (12 on entecavir and 1 on lamivudine).

Ten patients (9.3%) experienced HBV reactivation during their disease course. Three of them were on antiviral prophylaxis and four had positive anti-HBs. All of these reactivations were only transient low-grade viraemia with HBV DNA level <20 IU/ml. Spontaneous resolution of viraemia in less than 12 months' time were observed in all of these patients. None of the reactivation resulted in any adverse clinical event including acute hepatitis, hepatic failure or mortality.

Among all synthetic and biological DMARDs, only the use of methotrexate was found to be a significant predictor of HBV reactivation ($p<0.05$). Other parameters including age, the lack of antiviral prophylaxis, negative anti-HBs status and anti-HBs titre did not predict HBV reactivation.

Conclusions: HBV reactivation among RA patients with HBsAg-/anti-HBc +status and undetectable HBV DNA at baseline was infrequent. Reactivation may occur in patients with positive anti-HBs or on antiviral prophylaxis, but was unlikely to be associated with adverse clinical outcome. The use of methotrexate was a predictor of HBV reactivation in these patients.

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