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**Background:** Gout, the most common type of inflammatory arthritis, is considered as a predominant male disease. Notwithstanding, there is an increased risk of gout in females after the menopause.

**Objectives:** Our objective was to assess differences in the clinical features between female and male patients.

**Methods:** Data of newly diagnosed gout patients attending the rheumatology outpatient clinics of one secondary and one tertiary i.e. university centre in the south of the Netherlands were used. We compared baseline characteristics of males and females regarding to demographics, BMI, presence of tophi, medication use (diuretics, prophylaxis of gout and uric acid lowering drugs), serum and urine concentration of uric acid and creatinine, and comorbidities. Additional, fractional excretion of uric acid (FEUA), calculated as (urinary uric acid x serum creatinine) / (urinary creatinine x serum uric acid) was compared. FEUA gives the percentage of uric acid renally filtered and thus excreted in the urine (normal range 7%–12%). Independent t-tests and chi square were used to assess differences between females and males statistically.

**Results:** 66 female (16.6%) and 331 male (83.4%) patients with gout (MSU crystals 60.6% vs 68.6%, respectively) were included. At baseline, females compared to males had a significantly higher age (73±12 vs 63±13 years, p<0.001), BMI (30.1±5.2 vs 28.7±4.7 kg/m², p=0.004) and diuretic use (63.6% vs 27.6%, p<0.001). Females had also a significantly higher percentage of comorbidities, including hypertension (77.3 vs 59.5%, p<0.001), diabetes (48.5 vs 22.7%, p<0.001) and chronic kidney disease (eGFR of 46.4±24.2 vs 62.5±22.9, p<0.001). There was no significantly difference in serum and urine uric acid concentration, current urate lowering therapy and increases the risk of gout in the female population. Although diuretic use has proven to be a safe and effective first-line treatment for hypertension, our results suggest that diuretic use in combination with a decreased renal function is associated with an increased risk at developing gout in females, and possibly needs reconsideration. Furthermore, despite the fact that the FEUA was similar distributed between gout groups, it seems to have a lower urinary uric acid excretion. However, the number of patients with tophi and nephro lithiasis are comparable between the genders. This suggests that the urate burden is similar but that the clinical profile for the development of gout differs due to the uric acid production vs excretion. In depth analysis of our population underlines the differences in female and male gout patients which highlight the need for more research into pathophysiology and management of gout between sexes.

**Disclosure of Interest:** None declared

**References:**


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**MICROPROTEINURIA AS A MARKER OF SUBCLINICAL GOUTY NEPHROPATHY**

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**Background:** The prevalence of kidney damage in patients with gout ranges from 30% to 70%. Currently the concept of ‘gouty nephropathy’ (GN) comprises all renal pathologies due to gout. There is no clear opinion whether hyperuricemia is a marker of renal dysfunction or risk factor. It is important to identify the early stages of GN as its course is subclinical for a long period of time. Microproteinuria is the first harbinger of kidney damage. However, predictors of GN have not been established for today.

**Objectives:** To establish predictors of GN.

**Methods:** A total of 103 patients with chronic gouty arthritis were examined in rheumatology department of Ternopil University Hospital. All patients had no history of any kidney disease. ELISA method was used to determine microproteins in urine. Subsequently, patients were divided into 2 groups: I (n=58) – patients with subclinical gouty nephropathy, abnormal microproteins level (56.3%), II (n=45) – control group, patients without kidney damage, normal microproteins level (43.7%). Statistical analysis was performed with STATISTICA software.

**Results:** Patients with subclinical gouty nephropathy had a higher prevalence of arterial hypertension and metabolic syndrome. The prevalence of osteoarthritis, diabetes mellitus and dyslipidemia was the same in both groups. Also, group I patients showed longer duration of the disease, greater radiologic changes, higher levels of hyperuricemia, tophi, work incapacity, greater number of affected joints and more frequent changes in urinalysis than the control group.

**Conclusions:** Formation of GN is asymptomatic, causing delays in early diagnosis, but can be suspended timely. Gouty nephropathy develops in 56.3% of patients with chronic gout arthritis, and manifests by microproteinuria in the early subclinical stages. Duration of the disease, obesity, presence of tophi, arterial hypertension, hyperuricemia, increased triglycerols and low-density lipoproteins levels were found to be predictors of gouty nephropathy.

**References:**


Tuberculous spondylodisclitis remains a major global public health problem in endemic countries that affects mostly young adults in their most productive years. Thoracolumbar junction seems to be the most common site of the spinal column involvement in spinal tuberculosis (95%) and cervical spine is concerned in only 5% of cases. The delayed diagnosis, between 3 and 20 months, explains the frequency of neurological deficits which are found in proportions of 20% to 40%. For the diagnosis of spinal tuberculosis, magnetic resonance imaging is more sensitive imaging technique than x-ray and more specific than computed tomography. Antituberculous treatment remains the cornerstone of treatment. Surgery may be required in selected cases. With early diagnosis and early treatment, prognosis is generally good.

Conclusions: Cervical Pott’s disease is a rare localization. The diagnosis is easy in front of the cervical signs. The conservative management of cervical spine immobilization and antituberculous chemotherapy remains a sufficient attitude to healing. Surgery is reserved in case of neurological aggravation or spinal instability.

References:

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