AB1281

INCIDENCE AND CHARACTERISTICS OF HEALTHCARE-ASSOCIATED INFECTION (HCAI) IN HOSPITALISED PATIENTS WITH RHEUMATOLOGIC DISORDERS AT ALEXANDRIA MAIN UNIVERSITY HOSPITAL

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Background: Healthcare-associated Infection (HCAI) is an important cause of morbidity and mortality in autoimmune diseases⁽¹⁾. The increased susceptibility to infections in such patients is explained by abnormalities of the cellular and humoral immune responses, as well as the use of immunosuppressive drugs. Infection in these patients can present with minimal signs and symptoms or with atypical features in unusual locations that considerably can delay the diagnosis and worsen the outcome. There are few detailed systematic reports on HCAI in rheumatology; most previous reports investigated HCAI in the setting of systemic lupus erythematosus (SLE) but lack other connective tissue diseases⁽²⁾.

Objectives: To determine the incidence and characteristics of HCAI in patients with rheumatologic diseases admitted to the Rheumatology Unit at the Alexandria Main University Hospital (AMUH) on 2017.

Methods: A One-year duration prospective observational study to elucidate the incidence and characteristics of HCAI in patients with underlying rheumatologic diseases who were admitted to the Rheumatology Unit of the Internal Medicine Department at AMUH between January 1st and December 31st 2017.

Results: A total of 516 patients (423 female (82%) and 93 male (18%)) with underlying rheumatologic diseases and disease duration of 6.03±4.18 years were admitted between January 1st and December 31st 2017. The mean age was 32.18±9.54 years, and the mean length of hospitalisation was 10.04±5.76 days. HCAI occurred in 14.9% (n=77) of patients with a total number of infections of 81 (15.69%) (four cases had more than one episode of infection in more than one site with a different organism during the same admission). Gram -ve bacilli were the most commonly isolated organisms (46.3%; n=38) followed by Gram +ve cocci (25.6%; n=21). The urinary tract was the most commonly documented site of infection (39.5%; n=32) followed by blood stream (18.5%; n=15), and *Klebsiella spp* (17.9%; n=15) was the most frequently identified infectious agent, followed by *Methicillin-resistant Staphylococcus Aureus* (MRSA) (14.3%; n=12). Of the total cases with HCAI (n=77), 85.7% (n=66) treated, 7.8% (n=6) deteriorated and shifted to the ICU with multiorgan failure, 5.2% (n=4) died, and 1.3% (n=1) (a case with meningitis) were referred to another specialised hospital.

Conclusions: Despite the improvement in healthcare services, the incidence of HCAI infection in our inpatient population is still high and represents a burden on our resources. Although most cases were treated with appropriate antimicrobials, HCAI is still the cause of deterioration and death in a considerable percentage of patients with rheumatologic diseases.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3336

AB1282

TYPE OF PATIENT REFERRAL TO EARLY ARTHRITIS CLINIC (FLOW AND FATE)

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Background: Early Arthritis clinic (EAC) has a major contribution in Rheumatology outpatient services. Clinically, it gives a unique opportunity to assess, diagnose and classify various Rheumatic and Musculoskeletal diseases (RMD) during the initial phase of the disease process. Studying the patient's profile of EAC population aids in better management from the epidemiologic point of view. The average referral to EAC in Dubai hospital is 2 weeks over the last 5 years.

Objectives: The current study was conducted to explore the characteristics and common diagnoses of patients referred to EAC Rheumatology clinic in Dubai Hospital.

Methods: A review of the Electronic Medical Record of 117 patient presented to EAC between August 22nd 2017 and December 31st 2017. The following data were extracted from EMR and patient's files: Type of patient referral to EAC, initial visit diagnosis as well as concordance between initial diagnosis and established diagnosis.

Results: Autoimmune Rheumatic Diseases (ARDs) represents 41.1% of new cases diagnosed in the EAC. The number and percentage of the whole new cases

diagnosis is as shown in the following table while the type/percentage of patient presentation to EAC is shown in the graph.

Abstract AB1282 – Table 1

Disease category	Number	Percent (%)
Mechanical and soft tissue rheumatism	31	26.5
Fibromyalgia	10	8.6
Rheumatoid arthritis	19	16.2
Systemic lupus erythematosus	7	6
Spondyloarthritis	9	7.7
Vasculitis	3	2.6
Other	19	16.2
Osteoporosis	19	16.2

Occasionally, patients' clinical features were inconclusive at the initial presentation. Knowing that most patients presented within two weeks of symptoms onset to EAC, hence classification at initial visit was difficult in 16.2% (others or undifferentiated inflammatory arthritis).

on review of the initial visit diagnoses and the final established diagnoses after 3 months, we have found 97 of 117 has the same diagnosis, i.e. 82.9% concordance.

Abstract AB1282 – Figure 1. Type of patient presentations to EA in %

Conclusions: Early Arthritis Clinic grants an efficient access to patients with inflammatory and inflammatory back pain. However, a need of a standardised tool to triage patients with different musculoskeletal diseases to prevent delayed appointments to EAC.

We suggest adding Osteoporosis (Bone metabolic disorders), Undifferentiated (arthritis, CTD, SPA) and non-Rheumatic diseases to initial diagnosis to increase the current concordance.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3015

AB1283

THE PREVALENCE AND COMORBIDITIES ASSOCIATED WITH PSORIATIC ARTHRITIS IN PATIENTS WITH PSORIASIS: AN OBSERVATIONAL COHORT STUDY

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Background: The prevalence and comorbidities of psoriatic arthritis (PsA) varies in different parts of the world and there is little clinical and epidemiological data from the Egyptian

Objectives: To investigate the prevalence of psoriatic arthritis (PsA) in patients with psoriasis (PsO), and to identify comorbidities associated with it.

Methods: The study was designed as an observational cohort study involving patients with psoriasis. Information was collected about lifestyle, habits, comorbidities, and psoriasis activity. Patients were classified as having PsA if they fulfilled the criteria of the Classification of Psoriatic Arthritis Study group (CASPAR).

Results: The data was obtained from the 371 psoriasis patients. The mean age was 40.0±16.6 years, 42% were women, and 58% were men. A diagnosis of PsA was found in 104 patients (28%), of whom 34.6% had peripheral involvement, 15.4% had isolated axial involvement, and 50% had both peripheral and axial involvement. The PsA onset was preceding psoriasis in 48%, together with psoriasis in 40% and following psoriasis in 12%. Family history of PsO and PsA was positive in 21.6% and 8.4% respectively. PASI score of our patients ranged from 1–30 with a mean of 8.77±6.33, which were relatively higher in PsA patients. Comorbidities in form of diabetes mellitus, hypertension, liver disease, HIV and dyslipidemia

were found in 14.6%, 10.5%, 10.2%, 0.3% and 0.5% respectively. Smoking was found in only 10 patients (2.7%).

Conclusions: The prevalence of PsA in Egyptian patients with psoriasis appears to be within the range reported in other studies. Whereas, most of PsA onset was found to precede the psoriasis.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7571

AB1284

PRELIMINARY DATA OF VACCINATION STATUS, POST VACCINATION IMMUNITY AND LATENT TUBERCULOSIS IN PATIENTS WITH CHRONIC INFLAMMATORY DISEASE IN A RHEUMATOLOGY CONSULTATION IN ST RAFAEL'S HOSPITAL IN BARCELONA

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Background: Chronic inflammatory diseases (CID)(Rheumatoid arthritis(RA), Psoriatic arthritis(PsA) and ankylosing spondylitis(AS) are treated with disease modifying antirheumatic drugs(DMARDs). The most common adverse events are infections so an adequate vaccination is necessary before starting these treatments

Objectives: Determine the vaccination status, post-vaccination response and presence of latent tuberculosis(TB) in patients(pts)with CID

Methods: Before treatment with DMARDs, hepatitis C virus(HCV) antibodies, hepatitis B(HBV)surface antigen are determined. Following the guideline of Spanish Society of Rheumatology, before start a biological treatment(BT), latent tuberculosis(TB)screening is done by PPD and booster test. We and Preventive Medicine Department(PMD) of Vall Hebron Hospital(VHH) established vaccination protocol for pts with CID treated with DMARDs or/and BT:anti pneumococcal vaccination, virus serological status(varicella zoster IgG, measles IgG, anti-hepatitis A IgG, HBV surface antigen, HBV anti-surface antigen, HBV anti-core antigen and anti-HCV) and quantiferon(QT) test by assessment latent TB. Vaccines were administered depending on the above tests such as the determination of the post-vaccination HBV serology. Positive QT pts were referred to Infectious Diseases Department of VHH and received Isoniazid for 6 months

Results: From October 2016 to November 2017,123 pts with CID(including new onset and chronic disease) were referred to PMD. The pts were classified:81 RA (16 BT/65 DMARDs);25 PsA(9 BT/16 DMARDs),13 AS(10 BT/3 DMARDs),5 others(2 BT/3 DMARDs):2 juvenile idiopathic arthritis,1 reactive arthritis,1 monoarthritis and 1 polymyalgia rheumatica. Pts with BT were treated:14 RA with combined therapy(CT) and 2 with monotherapy;9 AS with monotherapy and 1 with CT,2 PsA with monotherapy and 7 with CT.19 pts had QT(+):2 had previously PPD(-);3 had previously PPD(+) and it was unknown in 14. Pts with PPD(+) and QT(+)(n=4), all of them who received BT(n=3) had been treated with isoniazid. The patient treated with DMARDs didn't received it. Pts QT(+) and previous PPD(-)(n=2):1 with BT for years and never before had been treated with isoniazid, so this treatment was started. The other with DMARDs started treatment with isoniazid as she was going to start BT in a short time. The rest of the pts QT(+)(n=14) didn't have a previous PPD(all DMARDs).11 received prophylaxis with isoniazid and 3 didn't, because they didn't require BT soon.19% of pts had positive HBV's serology, so they didn't receive HBV vaccination. 81%(n=100) had a negative anti-Ag surface HBV.92% of them received the vaccination, and from them, 9% didn't develop immunologic response so they needed revaccination(3 received TC BT-DMARDs and 5 DMARDs in monotherapy).42% developed immunologic response and in 49% we are waiting for the results.16% had a negative HAV's serology and all of them received the vaccination

Conclusions: The quantiferon can detect latent TB in patients with negative PPD and booster. Most patients need vaccination to HBV. Check the immunity from HBV is necessary after vaccination to know if they need revaccination. In our preliminary data we have observed absence of immunity to HBV in patients who are treated with BT (with CT) and also in patients who are treated with synthetic DMARDs.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.4406

AB1285

SERUM INTERLEUKIN 33, A POSSIBLE NEW MARKER PREDICTING THE DEVELOPMENT OF VASCULITIS IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is an autoimmune disease characterised by abnormal production of autoantibodies and proinflammatory cytokines. Although interleukin-33 (IL-33), a novel member of the IL-1 family, has

been reported to have proinflammatory effects, the association of IL-33 with SLE has not been fully investigated¹

Objectives: To estimate serum levels of IL- 33 in Egyptian patients with SLE and in controls, and to find out any relation between IL-33 serum levels in SLE patients and disease activity in addition to other clinical and laboratory criteria.

Methods: 60 SLE Egyptian patients (53 females and 7males) diagnosed according to systemic lupus international collaborating clinics (SLICC); new classification criteria 2012 and 20 healthy controls matched for age and sex were included. Patients with diseases suggesting the possibility of increased serum IL-33 were excluded² 27 SLE patients were diagnosed clinically as having vasculitis and this was confirmed by laboratory and imaging studies. Serum IL-33 was measured by sandwich ELISA Kit. Disease activity was assessed using SLE disease activity index (SLEDAI) score.³

Results: Using Mann-Whitney U test, median serum level of IL-33 (30.3 pg./ml) was significantly higher in patients with SLE than that of healthy controls (24.80, p=0.003). Using logistic regression analysis, SLE patients with high IL-33 serum levels have 3.8 times higher risk of developing vasculitis (OR 3.8 (1.1–13.6, 95% CI: p=0.01) and 3.2 times higher risk of developing oral ulcers (OR 0.3.2 (1.2–11.7, 95% CI: p=0.033.) than those with lower IL-33 serum Levels. No significant correlation was found between serum levels of IL-33 and total SLEDAI score or any of the other clinical or laboratory criteria.

Conclusions: Our findings suggest that IL-33 may be considered as a possible new inflammatory marker predicting the development of vasculitis and/or mucosal ulcers in SLE patients. Neutralisation of IL-33 may hopefully result in a new therapeutic option for these patients. Further studies are warranted to get more conclusive results.

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Acknowledgements: We acknowledge the efforts received by all staff members of departments of Rheumatology and clinical pathology at Mansoura University Hospital, Egypt.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2595

AB1286

ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS, UNDIFFERENTIATED (U) SPONDYLOARTHRITIS (SPA) IN INDIA: RESULTS FROM WHO ILAR COPCORD INDIA PROGRAM STAGE I SURVEY 2000–2010

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Background: Using a low cost low infrastructure model, the WHO ILAR COPCORD (Community Oriented Program for Control of Rheumatic Diseases) surveys have covered several population in Asia and Latin America. The reported prevalence of AS based on large sample surveys was 0.2–0.3 in China and 0.12 in Iran. We used the Bhigwan COPCORD model to complete comprehensive surveys at several urban and rural site in India.

Objectives: To describe the prevalence of SpA in India with a focus on AS

Results: 51 741 population (66% rural) in 11 sites all over India was screened using a suitable COPCORD core questionnaire and protocol. Stage I survey was carried out in 3 concurrent overlap phases. House to house visit identified respondents with current/past musculoskeletal pain (last 7 days). Paramedics interviewed respondents to map MSK pain and record patient centric outcome including an Indian version HAQ (Phase 2). Clinical evaluation was carried out by rheumatologists with minimal investigations (Phase 3). The diagnosis was clinical. Survey sites and samples were chosen by convenience. Data was centrally processed and analysed using standard software; significant p<0.05. Data standardised (age-gender) as per; India census 2002 adjusted prevalence reported.