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

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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

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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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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.