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


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

A. Erra1, H. Borrell1, L. López1, X. Martínez2. 1Rheumatology, Hospital San Rafael, 2Preventive medicine, Hospital Vall Hebron, Barcelona, Spain

Background: Chronic inflammatory diseases (CIDs) (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 starting 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-pneumococcoc 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 PDM. 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 monarthritis 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(+) and 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 receive 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. 52% of them received the vaccination, and from them, 9% didn’t develop immunologic response so they needed revaccination (3 received 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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ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS, UNDIFFERENTIATED (U) SPONDYLOARTHROPATHY (SPA) IN INDIA: RESULTS FROM WHO ILAR COPCORD INDIA PROGRAM STAGE I SURVEY 2000–2010

A. Chopra1, R. Ghoparde1, M. Saluja1, A. Verugopalan1, S. Sarmukaddam1, T. Kainifard2, K.M. Mahendranath3, on behalf of BJD-COPCORD Team India.

1rheumatology, Center for Rheumatic Diseases, Pune, India; 2rheumatology research, Tehran Univ of Medical Sciences, Teheran, Iran; 3rheumatology, Arthritis Center, Bangalore, India

Background: Using a low cost low infrastructure model, the WHO ILAR COPCORD (Community Oriented Program for Control of Rheumatic Diseases) survey has 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.

Disclosure of Interest: None declared


ANAYLISIS OF SPONDYLOITIS (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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