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AB1313

SYSTEMATIC SCREENING OF COMORBIDITIES IN CHRONIC INFLAMMATORY RHEUMATIC DISEASES IN DAILY PRACTICE: A RETROSPECTIVE MONOCENTRIC FRENCH STUDY ACCORDING TO RECENT EULAR GUIDELINES

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Background: In chronic inflammatory rheumatic diseases, comorbidities such as cardiovascular diseases and infections are more frequently observed than in general population and are suboptimally prevented, screened and managed.¹⁻⁴ A nurse-led programme demonstrated the short-term benefit on management of comorbidities in rheumatoid arthritis patients.⁵ EULAR recently published points to consider for reporting, screening, and preventing specific comorbidities in chronic inflammatory rheumatic diseases in daily practice.

Objectives: Our objective was to screen and report comorbidities in chronic inflammatory rheumatic diseases patients in daily practice according to recent EULAR guidelines.

Methods: We included patients with rheumatoid arthritis, spondyloarthritis, and psoriatic arthritis from November 2016 to November 2017 in a retrospective monocentric study in the rheumatology department of the Grenoble Alpes Teaching Hospital. Data regarding comorbidities were collected in a standardised multidisciplinary consultation with a rheumatologist, a specialised nurse and a hospital pharmacist, according to EULAR and French Society of Rheumatology guidelines. Data concerning cardiovascular diseases, infectious comorbidities, cancer screening, and osteoporosis were collected. Data about the rheumatic disease including treatment and disease activity were recorded. Adherence was analysed in consultation by the pharmacist. Recommendations were notified to the patients, his general practitioner, and rheumatologist on a standardised letter. Data were analysed as mean/SD if appropriate and percentage.

Results: We included 101 patients, 43 patients had rheumatoid arthritis, 45 had spondyloarthritis, and 13 were diagnosed with psoriatic arthritis. The mean age was 49.6 years old.^{14,9} 50 patients were followed in the hospital, 39 were followed by private practitioners and 12 were followed by both. All patients were treated with bDMARDs. In average, patients received 2,3 (SD 1,6) different biologic treatments. In our total population, 55,5% had influenza vaccination >1 year ago, 42,6% had an appointment to the dermatologist >1 year ago, 25% of the women between 50 and 75 years old had a mammography >2 years ago and 27,3% of women >50 years old with FRAX above threshold were not treated for osteoporosis. Moreover, 60,5% of patients with rheumatoid arthritis had a Heart Score >1% and 45,6% in the total population.

Conclusions: Our monocentric study confirmed that comorbidities are frequent and suboptimally prevented and managed according to the EULAR point to consider. An evaluation of the efficiency of our standardised consultation and intervention is necessary.

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AB1314

LACK OF ASSOCIATION BETWEEN ABO BLOOD GROUPS AND RHEUMATIC DISEASES IN CHINA: A SINGLE-CENTRE EXPERIENCE

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Background: Various genetic and environmental risk factors have been shown to be associated with the incidence of rheumatic diseases. Several studies have shown associations of ABO blood groups with various diseases.

Objectives: Our study aimed to determine whether there is an association between the types of rheumatic diseases and ABO blood groups.

Methods: The study included the patients, followed up at the Immunology-Rheumatology clinic between January 2010 and December 2017 for diagnosis of rheumatic disease, who had an ABO Rh blood data. Age, gender, type of rheumatic disease, ABO Rh blood groups were recorded.

Results: A total of 1551 patients were included in the study, such as 392 AS patients, 297 RA patients, 752 SLE patients and 110 pSS. The patients were assessed for blood types, 40.2% had O type, 26% patients had A type, 26.8% had B type, and 7.0% had AB type. AS, RA, SLE and pSS were more common in the patients with O blood type. The blood type where all the diseases are observed the least commonly was AB. There was no significant difference in the distribution of blood types in rheumatic diseases.

Conclusions: In our study, we thought that there was lack association between types of different rheumatic diseases and ABO blood groups.

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AB1315

MEDICATION USE AMONG PREGNANT WOMEN WITH RHEUMATIC DISEASES IN KOREA BASED ON THE NATIONAL HEALTH INSURANCE SERVICE-NATIONAL SAMPLE COHORT

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Background: Many rheumatic diseases (RD) predominantly affect women in their reproductive ages. Medication use during pregnancy is an important issue in women with RD since it may affect the health of both fetus and the mother.

Objectives: This study aimed to characterise the status of medication dispensed for Korean women with RD in pre-gestational period and during pregnancy.

Methods: Women aged between 20–44 years and diagnosed as RD and had delivery after the diagnosis of RD were identified from National Health Insurance Service-National Sample Cohort (NHIC-NSC) (2009–2013). Rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), and ankylosing spondylitis (AS) were included as RD. We analysed prevalence of RD related medication including disease-modifying antirheumatic drugs (DMARDs), NSAIDs, and corticosteroids (CSs) dispensed between the pre-gestational periods of 3 months before pregnancy until delivery. We also analysed prevalence of other medications and supplements which are commonly dispensed during pregnancy in women with RD and the age and sex matched controls.

Results: There were 71 deliveries among 1059 women with RD. In RD pregnancies, 54.9% had taken at least 1 RD related medications. The prevalence of DMARDs dispensing during pregnancy was 23.9%, CSs 43.7%, and NSAIDs 38.0% in RD population. Although usage of antibiotics and medication for thyroid diseases during pregnancies were not different between the women with RD and the control, use of vitamin and iron supplements were significantly higher in the women with RD (38.0% vs 13.4%, $p < 0.0001$).

Abstract AB1315 – Table 1 RD-related. medication dispensing prevalence by pregnancy period (N=71)

	Pre-pregnancy	1st Trimester	2nd Trimester	3rd Trimester
cDMARDs	17 (23.9)	15 (21.1)	14 (19.7)	12 (16.9)
Azathioprine	1 (1.4)	1 (1.4)	1 (1.4)	1 (1.4)
Cyclosporin	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Hydroxychloroquine	17 (23.9)	14 (19.7)	13 (18.3)	10 (14.1)
Sulfasalazine	0 (0.0)	0 (0.0)	1 (1.4)	2 (2.8)
Tacrolimus	1 (1.4)	1 (1.4)	0 (0.0)	0 (0.0)
Others	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
bDMARDs	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Corticosteroids	31 (43.7)	24 (33.8)	24 (33.8)	22 (31.0)
NSAIDs	27 (38.0)	13 (18.3)	3 (4.2)	1 (1.4)

Conclusions: Medications are frequently required during pregnancies of women with RD. RD are a significant burden for pregnant women requiring increased number of medication use.

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AB1316 HOSPITAL ADMISSION TRENDS AND SHORT-TERM OUTCOME FOR IGA VASCULITIS IN CHILDREN AND ADULTS IN WESTERN AUSTRALIA

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Background: Immunoglobulin A vasculitis (IgAV), formerly called Henoch-Schönlein purpura, is an immune complex mediated small-vessel vasculitis that preferentially affects the skin, intestines and kidneys. While more common in children, IgAV is not unusual in adults, where it has been associated with worse outcomes.

Objectives: To compare hospital admission rates and outcomes over time between adult and paediatric inpatients with IgA vasculitis

Methods: Data were extracted from a state-wide registry for all hospital admissions in Western Australia (WA) between 1980 to 2015 for patients with a primary or secondary diagnosis of IgAV (ICD-9-CM code 287.0/ICD-10-AM code D69.0). Paediatric cases were defined as those ≤19 years at first diagnosis.

Results: From a total 764 patients admitted to hospital with an IgAV diagnosis 508 (66%) were paediatric and 256 (34%) adult cases. IgAV was the primary diagnosis in 463 (91.1%) paediatric and in 123 (48%) adult patients (p<0.01). In children, mean age at primary diagnosis was 5.6 years of (range 0–19) versus 50.2 years (range 20–91) in adults. Both groups had similar proportions of Indigenous (3.5 vs 1.6%, p=0.4) and male patients (59 vs 51.2%, p=0.3). Over the observation period, the annual rates per 100,000 for a first admission for IgAV declined from 4.2 to 0.4 for children and from 0.42 to 0.2 for adults, while length of stay in days decreased from 5.8 to 1.8 for children and increased from 10.5 to 21.1 for adults. Three adults (2.4%) but no child required ICU admission, while one adult (0.7%) and no child died in hospital. Readmission rates for IgAV were considerable and higher in children than adults (25.6% vs 18.7%, p=0.1).

Conclusions: Admission rates for IgAV in children in WA have declined steeply over the last decades and now almost equate admission rates for adults. The reduction in length of stay and absence of in-hospital mortality support an increased willingness or necessity to manage children with IgAV outside the hospital setting despite a significant readmission rate. In contrast, hospital admission for IgAV in adults associates with prolonged length of stay and a slight risk for ICU admission and in-hospital mortality.

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AB1317 IDENTIFICATION OF CARDIOMETABOLIC ABNORMALITIES IN THE FIRST VISIT TO A PREVENTIVE CARDIO-RHEUMA CLINIC

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Background: Rheumatoid arthritis (RA) is a chronic, systemic and autoimmune disease with articular and extra-articular manifestations. RA is associated with increased prevalence of comorbidities and higher cardiovascular risk when compared to general population. Atherosclerotic cardiovascular (CV) events are the leading cause of death in RA. In a recent meta-analysis, hypertension, type 2 diabetes mellitus (T2DM) and hypercholesterolemia were shown to increase the risk of CV disease in this population.¹ A study reported a prevalence of hypertension 29.8%; dyslipidemia 27.1% and T2DM 12.4% in Mexican-mestizo RA patients.² The cardio-rheuma clinics were designed to provide healthcare for CV diseases in patients with rheumatic conditions. Specific guidelines recommendations have been published to enhance detection and management of specific comorbidities associated to RA.³

Objectives: To identify the prevalence of unknown cardiometabolic risk factors in a Mexican-mestizo cohort with RA.

Methods: Cross-sectional, observational study. Patients who fulfilled the 1987 ACR and/or the 2010 ACR/EULAR classification criteria were consecutively recruited. Patients were divided in two groups, with and without history of cardiovascular comorbidities. Clinical history and physical exam were performed by a general physician in a cardio-rheuma clinic. Fasting blood glucose and lipid profile were performed on all subjects. Categorical variables are expressed as percentages and numerical variables as means±standard deviations.

Results: A total of 296 patients were included. Demographical characteristics are shown in Figure 1. Hypertension was the most frequent comorbidity (27.7%), followed by dyslipidemia (26.7%) and T2DM (13.5%). Many of the patients without history of cardiometabolic risk factor had important findings on baseline visit: 18.7% had altered blood pressure without history of hypertension, 76.5% had an abnormal lipid profile without history of dyslipidemia, and 21.5% had an altered fasting glucose without history of T2DM.

A. Demographic data		
Characteristic	N= 296	
Age (years), mean ± SD	55.8 ± 8.5	
Female, n (%)	275 (92.9%)	
Active or former smoker, n (%)	27 (9.1%)	
T2DM history, n (%)	40 (13.5%)	
Hypertension history, n (%)	82 (27.7%)	
Dyslipidemia history, n (%)	79 (26.7%)	
Steroids use	174 (58.8%)	
bDMARDs, n (%)	20 (6.8%)	
Methotrexate, n (%)	249 (84.1%)	
Leflunomide, n (%)	61 (20.6%)	
DAS 28-CRP, mean ± SD	3.36 ± 1.4	
Disease duration (years), mean ± SD	10.91 ± 13.3	
B. Cardiometabolic abnormalities		
	Previous history	No previous history
Hyperglycemia (n)	40	256
Fasting plasma glucose levels (mg/dL)		
≤99 mg/dL, n (%)	13 (32.5 %)	201(78.5%)
100-125 mg/dL, n (%)	13 (32.5 %)	43 (16.8 %)
126-199 mg/dL, n (%)	6 (15 %)	12 (4.7 %)
≥ 200 mg/dL, n (%)	8 (20 %)	0
Hypertension (n)	82	214
Blood pressure (mmHg)		
Blood pressure ≤ 140/90 mmHg, n (%)	52 (63.4 %)	174 (81.3 %)
Systolic blood pressure ≥ 140 mmHg, n (%)	15 (18.3 %)	26 (12.2 %)
Diastolic blood pressure ≥ 90 mmHg, n (%)	5 (6 %)	13 (6.1 %)
Blood pressure ≥ 140/90 mmHg, n (%)	10 (12 %)	1 (0.5 %)
Dyslipidemia (n)	79	217
Normal lipid profile, n (%)	14 (17.7 %)	51 (23.5 %)
Altered lipid profile*, n (%)	65 (82.3 %)	166 (76.5 %)

Abstract AB1317 – Figure 1