Objectives: The aim of this study is to determine the prevalence of cardiac manifestations and to assess their predictive factors in a population of Moroccan patients suffering from SpA.

Methods: We have conducted a cross-sectional study over two months in our department of rheumatology. All SpA patients fulfilled ^{ASAS 2009} criteria. They all have had a cardiac check up with research of clinical cardiac manifestation, 12-lead electrocardiogram and trans-thoracic echocardiography.

Data analysis was carried out using the SPSS Statistics 20 software. A univariate analysis as well as multivariate regressions were carried out to identify the factors associated with cardiac manifestations.

Results: We have included 61 men and 31 women with a mean age of 37.34 ±12.77 years old. The mean disease duration was 10.59±7.63. The median CRP was 9.60 mg/L (IQR 0–180), the mean ASDAS CRP 2.24±1.30 and the mean BASDAI 2.7±1.99.

Traditional cardiovascular risk factors in our series included dyslipidemia in 15 patients (18.3%), hypertension in 10 patients (10.9%) and type 2 diabetes in 7 patients (7.6%). Mean BMI was 23.88±5.83 Kg·m⁻². Twenty nine patients (31.9%) were overweight and 10 patients (11%) were obese. Eight patients (8.7%) smoked and 3 patients (3.3%) used alcohol whereas 19 patients (20.7%) had a history of smoking and 6 patients (6.5%) had a history of alcohol use.

Cardiac manifestations were found in 12 patients (13.6%): 3 (3.3%) had aortic regurgitation (AR), 1 (1.1%) had aortic dilatation, 1 (1.1%) had aortic thickening, 2 (2.2%) had mitral thickening, 1 (1.1%) had mitral regurgitation (MR), 1 (1.1%) had mitral stenosis (MS), 3 (3.4%) had pericarditis and 2 (2.2%) had bundle branch block.

In comparison with the group without cardiac manifestations, axial involvement, current enthesitis and extra-articular manifestations were common in patients with cardiac involvement. Furthermore, uveitis was frequent in patients with aortic dilatation and MR. Patients with AR and MS had higher ESR and disease activity compared to the group without heart disease. Patients with pericarditis had an accelerated ESR unlike the group without cardiac involvement.

In univariate analysis, AR was significantly associated with ESR and ASDAS VS (OR=1.03 [1.003–1.063], p=0.028; 2.75 [1.062–7.123], p=0.037, respectively). Pericarditis was significantly associated with ESR (OR=1.03 [1.003–1.062], p=0.029).

In multivariate analysis, cardiac manifestations were significantly associated with current enthesitis and extra-articular manifestations (OR=4.48 [1.078–18.683], p=0.039 and 6.35 [1.156–34.893], p=0.033, respectively).

Conclusions: Heart disease was common in our study and was associated with the enthesitis involvement and the severity of SpA.

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AB1328 FLARES IN SPONDYLOARTHRITIS: PREVALENCE AND RELATED FACTORS

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Background: Spondyloarthritis is a chronic condition characterised by alternated periods of flares and stable disease.

Objectives: The aim of this study is to assess the prevalence of patient-reported flares and the validity of this concept through its related factors.

Methods: We have conducted a cross-sectional study over two months in our department of rheumatology. All SpA patients fulfilled ^{ASAS 2009} criteria.

Current and past flares over the last 3 months were recorded. Disease activity and functional status were assessed by the BASDAI score (0–10) and the Bath Ankylosing Spondylitis Functional Index (BASFI; 0–100), respectively. Data analysis was carried out using the SPSS Statistics 20 software. Univariate and multivariate regressions were performed to identify the factors associated with current flare.

Results: We included ninety two patients with SpA, 61 (66.3%) were men. The mean age was 37.34±12.77 years old. The mean disease duration was 10.59 ±7.63 year. The mean BASDAI was 2.7±1.99 and the median BASFI was 14 (IQR 0–100). Thirty-five patients (38%) received antitumor necrosis factor alpha (anti-TNF-α). Twenty-nine patients (31.5%) were currently in flare, and 6 patients (6.5%) reported only past flares.

In univariate analysis, patients reporting current flares had a current enthesitis (OR=3.14 [1.250–7.923], p=0.015) and higher values of BASDAI, ASDAS VS and

ASDAS CRP (OR=2.17 [1.085–4.362], p=0.029; 2.20 [1.448–3.359], p=0.0001; 2.23 [1.495–3.340], p=2.235, respectively). These patients had also more extra-articular manifestations (OR=3.37 [1.326–8.601], p=0.011).

In multivariate analysis, the following factors were associated with current flare: Inher BASFI (OR=1.05 [1.013–1.098], p=0.010), protein c-reactive (OR=1.087 [1.016–1.163], p=0.016), ASDAS VS (OR=10.99 [1.921–62.873], p=0.007), current enthesitis (OR=25.00 [2.185–286.146], p=0.01), the presence of extra-articular manifestations (OR=30.66 [1.709–550.049], p=0.02) and the use of non steroidal anti-inflammatory drugs during the last 3 months (OR=125.064 [3.33–4491.0], p=0.009).

Conclusions: Our study shows that assessment of flares may provide a good estimation of disease activity.

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AB1329 BIOLOGIC AGENTS AND RISK OF SERIOUS INFECTIONS IN RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS AND ANKYLOSING SPONDYLITIS: RESULTS BY INTEGRATING TEN-YEAR (2006–2015) ADMINISTRATIVE DATABASES IN THE ITALIAN REGION OF FRIULI VENEZIA GIULIA

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Background: Serious infections are a major concern for patients considering biologic agents for rheumatoid arthritis (RA) or psoriatic arthritis (PsA) or ankylosing spondylitis (AS). Evidence from meta-analyses is consistent with an increased risk of serious infections with biologic disease-modifying antirheumatic drugs (bDMARDs);¹ however, long-term real-life studies are scarce and controversial.

Objectives: To determine the risk of serious infections (i.e., need of hospitalisation) in patients affected by RA, psoriatic arthritis (PsA) or ankylosing spondylitis (AS), treated by bDMARDs in the Italian region of Friuli Venezia Giulia, approximately 1,200,000 inhabitants.

Methods: The regional health information system was used as the source of data. Administrative data from the hospital discharge records database, the medical prescription database, and the database of exemptions from medical charges were linked at the individual patient level through an anonymous univocal stochastic key. A cohort of patients diagnosed for RA, PsA or AS from 2006 to 2015 was identified from specific national exemption codes (006, 045, 054) and followed up to either the end of 2015, or hospitalisation with the main discharge diagnosis of infection, as ICD-9-CM codes, or death, or change of residency out of the Region. Multivariate Cox regression was used to estimate the hazard ratio (HR) of hospitalisation associated with bDMARDs and adjusting for age, sex, Charlson's comorbidity index, calendar year, prescription of steroids and of csDMARDs. Use of bDMARDs was treated as a time-dependent variable.

Results: Overall, the cohort consisted of 5596 subjects: 3216 (57.5%) with RA,¹⁷⁰² (30.4%) with PsA, and 678 (12.1%) with AS. Of them, 940 patients (16.8%) had received at least one prescription of a bDMARDs during the study period. During follow-up, 193 (3.4%) subjects were admitted to the hospital with a primary diagnosis of infection. The most frequent infections were upper and lower respiratory tract infections (86/193, 44.5%), followed by sepsis (19/193, 9.8%), and soft tissue and skin infections (16/193, 8.3%). After adjusting for the abovementioned variables, when starting a bDMARD, the risk of infections was significantly increased, with an observed increased risk of almost 2-fold by the time of the bDMARD prescription (HR 1.694, 95% CI 1.158–2.478, p=0.0066). Compared with patients <40 years if age, the elderly (>=65 years) showed a much higher risk of infections (HR 3.919, 95% CI 2.286–6.716, p<0.0001). Analyses stratified by disease indicated that RA, PsA, and AS patients starting biologic medications have increased risk of infection.

Conclusions: By integrating the information coming from ten-year administrative databases, RA, PsA and AS patients starting bDMARDs are at high risk of serious infections. This risk is much higher in the elderly. Upper and lower respiratory tract