46%. Regarding pharmacological therapy a higher proportion of patients received conventional DMARDs 90% see table 1. The prevalence of comorbidities was associated with sex and disease activity but did not have any association with pharmacological therapy see table 2.

Abstract SAT0744HPR – Table 1 Characteristics. of patients with RA and comorbidities

CHARACTERISTICS n (%)	WITHOUT COMORBIDITY		WITH ANY COMORBIDITIES	
	n	%	n	%
SEX				
FEMALE	2865	45%	2289	36%
MALE	795	12%	427	7%
DAS 28				
REMISION	1975	31%	1499	24%
LOW DISEASE ACTIVITY	581	9%	554	9%
MODERATE DISEASE ACTIVITY	929	15%	565	9%
SEVERE DISEASE ACTIVITY	175	3%	98	2%
MEDICATIONS				
Conventional DMARDs	2352	37%	3072	48%
Biological DMARDs	359	6%	580	9%

Abstract SAT0744HPR – Table 2. Assoc of comorbidities, sex, and disease activity.

Variable	PR*	IC 95%	P VALUE
Sex	7.21	6.58–7.89	0.000
DAS28	1.18	1.10–1.27	0.000
Therapy	0.91	0.86–0.96	0.000

PR: prevalence ratio

Conclusions: As other studies conducted in Asian or Australian populations high blood pressure is the most common disease among patients with RA followed by osteoporosis.¹ Sex is associated with higher comorbidities. According to these results it is important to consider the patient's context, medical conditions, and the number of comorbidities in order to understand the complexity of the management of patient with RA.

REFERENCE:

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7047

SAT0745-HPR TIME TO DIAGNOSIS, BUT NOT DISEASE DURATION, IS ASSOCIATED WITH POOR QUALITY OF LIFE IN SPONDYLOARTHRITIS: RESULTS FROM THE ASAS-COMOSPA STUDY

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Background: Spondyloarthritis (SpA) is a group of related chronic inflammatory conditions associated with impaired quality of life.

Objectives: To explore the potential associations between both "Time to Diagnosis" and "SpA Disease Duration" and current quality of life in SpA.

Methods: Using ASAS-COMOSPA, a large international cross-sectional study comprising 3984 patients with SpA, we investigated the association between either "Time to Diagnosis" (time from symptom onset to diagnosis) or "SpA Disease Duration" (time from symptom onset to study visit) and current quality of life at the single study visit. Data collected from 5 domains of quality of life in EQ-5D-3L were summarised as an index (ranging from -0.59 to 1.00). In separate models of linear regression, the association between the aforementioned chronology parameters with the quality of life index were investigated before and after adjustments for age, sex, education, HLA-B27, BMI, smoking, alcohol, and medication (NSAIDs, steroids, DMARDs, biologics) history.

Results: Data for 3923 patients (35.1% female; mean age 43.21 (SD: 13.89) years) were available for this analysis. The median (IQR) quality of life index was 0.64 (0.36–0.89) for the entire cohort. In multivariate analysis, "Time to Diagnosis" was significantly associated with poorer quality of life ($p=0.005$). Other factors and covariates associated with adverse quality of life were higher BMI ($p<0.001$), smoking ($p=0.003$), ever use of NSAIDs ($p<0.001$), ever use of steroids ($p<0.001$) and ever use of biologics ($p=0.002$). Factors associated with favourable quality of life were male gender ($p<0.001$), higher education ($p<0.001$) and HLA-B27 positivity ($p=0.006$) (Table). In contrast, "SpA Disease Duration" was not associated with the current quality of life index when corrected for confounders, including age.

Table: Association between Quality of Life index and "Time to Diagnosis" in Spondyloarthritis, adjusted to all potential confounders

Factors	p value	Coefficients (B)	95% CI for B
Time to Diagnosis (1 year blocks)	0.005	-0.002	-0.004, -0.001
Age	0.134	-0.001	-0.002, 0.000
Sex (M vs F)	<0.001	0.070	0.045–0.096
Current BMI	<0.001	-0.008	-0.010, -0.005
Smoking (pack-year)	0.003	-0.001	-0.002, 0.000
Alcohol intake (higher)	<0.001	0.026	0.015–0.037
Education (higher)	<0.001	0.036	0.019–0.054
HLA-B27 (+)	0.006	0.037	0.011–0.064
Ever NSAIDs	<0.001	-0.122	-0.147, -0.096
Ever Steroids	<0.001	-0.138	-0.163, -0.113
Ever DMARDs	0.489	-0.009	-0.034, 0.016
Ever Biologics	0.002	-0.037	-0.061, -0.013

Conclusions: In this global cohort of patients with SpA, time to diagnosis but not the duration of SpA appears to be associated with current quality of life, as assessed by the EQ-5D-3L index. Future work should explore geographic variation and whether this association is the same for axial and peripheral SpA disease.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6388

SAT0746-HPR COFFEE DECREASES METHOTREXATE INTOLERANCE AND INCREASES ITS COMPLIANCE IN RHEUMATOID ARTHRITIS (RA): A STUDY BY RHEUMATOLOGY NURSE COUNSELLORS

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Background: Methotrexate (MTX) is universally regarded as the 'anchor drug' for the treatment of Rheumatoid Arthritis (RA). Intolerance to MTX is the common cause of non-compliance that leads to poor disease control. The addition of coffee in the treatment regimen for MTX intolerance increases the patient compliance¹. Therefore, awareness about the effect of coffee and counselling for strict adherence to the recommended coffee schedule should be an essential part of patient's education.

Objectives: To assess the effect of coffee on MTX intolerance in patients with RA.

Methods: RA patients attending the Rheumatology clinic, willing to participate in the survey were enrolled in this study. All the patients were asked to take weekly MTX dose along with coffee as per schedule. The coffee schedule advised was as follows: 2 strong cups of coffee early in the morning on the day of the week on which the MTX was scheduled. This was repeated in the late evening 1–3 hours before the dose of MTX. The 3rd dose of 2 cups of strong coffee was repeated the next morning. This schedule was repeated every week synchronised with the weekly dose of MTX. All the patients were counselled and explain to follow the coffee schedule. All the information was collected in a pre-designed form.

Results: 600 patients were enrolled in this study. All the patients were treated with the weekly dose of MTX. Among 600 patients 285 (47.5%) did not have any MTX intolerance; 315 (52.5%) had MTX intolerance. In the latter category, 200 (63.5%) patients had minimal intolerance not requiring any intervention. The remaining 115 (36.5%) patients had moderate or severe MTX intolerance. Among these, 52 (45.2%) had complete relief of symptoms with the addition of coffee and were able to continue taking the advised dose of MTX; 17 (14.8%) had partial improvement and continued taking MTX but only with antiemetic; 14 (12.2%) were minimally better but were somehow managing; 14 (12.2%) did not get any relief and discontinued MTX. Another as 18 (15.6%) patients did not agree to take coffee and continued with the symptoms of MTX intolerance.

The result of persistent counselling and explaining the coffee schedule with the help of audio-visual aids help the patients to manage MTX intolerance and increases the MTX compliance to ~60% of those with MTX intolerance.