life and on disease treatment. Obesity increases the risk of developing psoriatic arthritis in the general population compared to normal-weight subjects. Obesity increases the risk of developing arthritis in patients with psoriasis, especially for HLA B27 negative and late onset forms.

Objectives: Aim of the study was to evaluate the incidence of overweight and obesity in a cohort of PsA patients, the differences between disease phenotypes and therapeutic response between patients with normal weight and overweight/obesity.

Methods: In this retrospective observational study 332 PsA patients, afferent to our unit between 2010 and 2017, were assessed. At each visit data on disease characteristics, BMI, ongoing treatment, joint count and clinimetric indexes were collected.

The baseline was defined as the onset of the disease in bio-naïve patients or the start of the last bDMARD therapy for patients previously treated with cs or bDMARDs, while the last follow-up is considered the last visit at our unit

Results: The 332 patients had a mean age of 52.5±7.3 years;35% of the patients were normal weight, 39.5% were overweight and 25.5% obese. No differences were observed in terms of disease characteristics according to BMI category at baseline and during follow-up, with comparable percentages of peripheral arthritis, enthesitis, dactylitis, axial arthritis or uveitis, as well as cutaneous psoriasis among the groups.

At baseline, obese patients had more tender(4.4±5.2 vs 2.3±3.6 p=0.003)and swollen joints(mean value 2.3 vs 1 p=0.03)and higher activity indexes, as for DAS28(3.3±1.2 vs 2.7±1.2 p=0.002)and DAPSA(15.6±9.9 vs 11.5±9 p=0.004) compared to normal weight patients. The same difference was observed between normal-weight and overweight patients, with higher values of DAS28(3.04±1.4 vs 2.7±1.2,p=0.17)and DAPSA(13.6±11 vs 11.5±9,p=0.025)in overweight patients. No significant difference was observed in patients treated with NSAIDs, csDMARDs or bDMARDs according to BMI category.

In 190 patients followed according to the tight control strategy, with evaluations every 3 months, the disease activity indexes after two years of follow-up became similar in obese patients compared to normal weight patients.

Among the normal-weight patients, 69.4% took csDMARDs,48.7% were treated with bDMARDs. 74.7% of obese patients took csDMARDs, while 36.1% took bDMARDs, with no statistically significant differences between the two groups (p=ns).

In particular low-disease activity according to DAPSA was achieved in 76% of normal weight patients, compared with 68.9% of obese patients (p=ns), and also the percentage of patients reaching Minimal Disease Activity in the two groups was comparable (28.4% vs 22.7%, p=ns).

Conclusions: Clinical manifestations of psoriatic disease do not seem to differ according to BMI category;however, at the first evaluation, obese patients appear to have more disease activity than non-obese patients.

At the same treatment intensity, obese patients seem to achieve a percentage of remission comparable to normal weight patients, suggesting that the an intensive treatment strategy allows to obtain optimal results also in a more challenging group of patients.

Disclosure of Interest: None declared

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THU0235 ANKYLOSING SPONDYLITIS AND RHEUMATOID ARTHRITIS HOSPITALISATION TRENDS IN THE US: DATA FROM NATIONAL INPATIENT SAMPLE

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Background: Ankylosing spondylitis (AS) imposes significant morbidity and disability in the affected population. Hospitalisation trends provide an insight as to

burden of disease and long-term data is lacking. We evaluated AS related hospitalisation trends in the US from 2001–13, comparing it to the more common inflammatory arthritis- rheumatoid arthritis (RA).

Objectives: To evaluate AS related hospitalisation trends in the US in comparison to the more common inflammatory arthritis- RA

Methods: Using the Nationwide Inpatient Sample (NIS) data from 2009–2011, we identified patients ≥18 years with AS and RA at primary diagnosis positions based on ICD-9 codes 720.0 and 714.0, 714.2, 714.30–714.33 respectively. We also excluded patients with psoriatic arthritis and inflammatory bowel disease to improve the specificity of codes used. We used the trend weight (contained in the variable TRENDWT) supplied by HCUP to study the annual trends of hospitalizations in AS and RA (2001–13). We used Stata version 13.0 (College Station, TX) and Joinpoint regression analysis software to calculate yearly trends.

Results: NIS database from 2001–2013 contained 36 883 (weighted count, n=175,356) patients with RA and 1377 (weighted count- 6,554) patients with AS. A decreasing trend in AS and RA hospitalizations was noted with an annual percentage change (APC) of 5.35 and 4.28 respectively (p<0.05) (table 1 and figure 1).

Conclusions: While recent studies have shown a rise in incidence of AS, the hospitalisation rates have declined similar to RA. Our study findings may reflect increased recognition of inflammatory back pain in the primary care setting and prompt referral and diagnosis due to improved imaging techniques of the spine and pelvis. Furthermore, the use of biologics, such as TNF and IL-6 inhibitors have significantly improved outcomes.

Disclosure of Interest: None declared

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THU0236 ANKYLOSING SPONDYLITIS RELATED FACTORS PREDICT THE PRESENCE OF CARDIAC CONDUCTION DISTURBANCES – A SWEDISH LONGITUDINAL COHORT STUDY

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Background: Despite a well-known association between ankylosing spondylitis (AS) and cardiac conduction disturbances (from here CCD), it's not clear which factors that predict their presence.

Year	RA, n	RA, N	SE, N	RA, per 1,000,000	SE, per 1,000,000	AS, n	AS, N	SE, N	AS, per 1,000,000	SE, per 1,000,000
2001	3473	16 883	927	564	29	120	578	66	19	2
2002	3797	17 527	842	579	26	131	593	66	20	2
2003	3206	15 028	648	490	18	115	536	60	18	2
2004	3469	16 328	853	527	26	133	622	66	20	2
2005	3256	15 390	646	497	18	132	642	72	21	2
2006	3073	14 415	631	456	17	106	499	54	16	2
2007	2892	13 779	713	437	20	95	455	49	14	2
2008	2759	13 004	574	406	15	112	527	62	16	2
2009	2419	11 803	517	373	14	97	471	55	15	2
2010	2377	11 380	471	363	14	93	451	56	14	2
2011	2386	10 939	488	348	13	99	460	54	15	2
2012	1986	9930	223	323	7	78	390	44	13	1.4
2013	1790	8950	291	299	9	66	330	42	11	1.4
TOTAL	36 883	1 75 356		5662		1377	6554		212	
APR		(-5.39)*		(-5.35)*			(-4.03)		(-4.28)*	

Objectives: To describe electrocardiographic (ECG) alterations in a cohort of patients with AS and if AS related factors at baseline predict the presence of CCD at 5 year follow-up.

Methods: In total 210 patients diagnosed with AS at 3 rheumatology clinics from Western Sweden participated 2009 in an observational longitudinal cohort study with a planned follow-up after 5 years. At follow-up 2014 physical examination, ECG, questionnaires, laboratory tests and radiographic examinations were repeated in 172 patients (82%). CCD was defined in the presence of AV block I (PQ duration ≥ 220 ms), AV block Ix (PQ duration 200–219 ms), AV block II-III, right and left bundle branch block (RBBB and LBBB), left anterior and posterior fascicular block (LAFB and LPFB) and pacemaker. Descriptive statistics and logistic regression analyses were performed in order to find predictors at baseline for the presence of CCD at follow-up. Baseline characteristics with a p-value <0.2 in univariate analyses (dependent variable *present CCD* (yes=1, no=0)) were included as independent variables in a forward stepwise multiple logistic regression analysis.

Results: In total 23 of the 172 patients (13.4%) had CCD at 5 year follow-up. Eight had developed a new CCD out of which 2 had required pacemaker implantation, 3 had a more aggravated CCD, whereas 10 patient had an unchanged and 2 a less pronounced. CCD compared with 2009 CCD and some of the patient characteristics are presented in table 1. (None had LPFB or AV block II-III). According to multiple logistic regression analysis, male sex (Odds ratio (OR) (95% CI) 4.7 (1.1–20.6)), increasing age (OR 1.1 (1.0–1.1) per 1 year), a history of anterior uveitis (OR 6.4 (1.1–36.2)), higher ASDAS-CRP (OR 3.6 (1.6–7.9)) and existing CCD at baseline (OR 42.4 (8.9–202.2)) were predictors for the presence of CCD at follow-up.

Abstract THU0236 – Table 1

	Patients without CCD (n=149)	Patients with CCD (n=23)
BASELINE CHARACTERISTICS 2009		
Male sex	74 (49.7)	19 (82.6)
Age, years	48.5 $\pm$ 12.3	58.7 $\pm$ 11.4
Symptom duration, years	22.5 $\pm$ 12.3	33.5 $\pm$ 14.3
HLA-B27	127 (85.2)	22 (95.7)
ASDAS-CRP	2.0 $\pm$ 0.8	2.7 $\pm$ 1.0
History of anterior uveitis	69 (46.3)	19 (82.6)
Aortic regurgitation [#]	20 (13.4)	6 (26.1)
At least one syndesmophyte	63 (42.3)	17 (73.9)
Reported comorbidity	36 (24.2)	11 (47.8)
1. Hypertension	5 (3.4)	0 (0.0)
2. Diabetes	7 (4.7)	4 (17.4)
3. Hyperlipidemia		
Medications	6 (4.0)	8 (34.8)
1. Anticoagulation	22 (14.8)	11 (47.8)
2. Potential antihypertensive	7 (4.7)	3 (13.0)
3. Lipid modulators	55 (36.9)	5 (21.7)
4. DMARDs		
CCD 2014		10 (43.5)
1. AV block Ix		7 (30.4)
2. AV block I		3 (13.0)
3. LAFB		1 (4.3)
4. RBBB		2 (8.7)
5. LBBB		3 (13.0)
6. Pacemaker		

Data are expressed as mean $\pm$ SD or number (%). [#] Missing data in 13 patients (10 without CCD and 3 with CCD) who did not underwent echocardiography at

baseline. DMARDs; disease-modifying anti-rheumatic drugs. ASDAS-CRP; ankylosing spondylitis disease activity score using C-reactive protein.

Conclusions: The presence of CCD in AS is dynamic. AS related factors, represented by baseline ASDAS-CRP and a history of anterior uveitis, predicted their presence at 5 year follow-up.

Disclosure of Interest: None declared

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THU0237 INFLAMMATORY LESIONS OF THE SACROILIAC JOINTS, BUT NOT OF THE SPINE, ARE OF HIGH UTILITY FOR AXSPA RECOGNITION: RESULTS OF THE ILOS-DESIR STUDY

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Objectives: To evaluate the performance of MRI inflammatory lesions suggestive of axSpA for the axSpA recognition

Methods: Observational cross-sectional national multicentre study. **Patients:** a) Recent onset axSpA patients: first, a sample of 100 patients representative in terms of imaging abnormalities of the global DESIR recent onset axSpA cohort were selected. b) Recent onset CBP patients: consecutive in- and outpatients consulting for recent (>3 months but <5 years) mechanical CBP, initiating before the age of 45 y and with a maximum age of 50 y, in four tertiary care Hospitals were included in the study. **Imaging:** MRI scans (T2-STIR and T1 sequences) of the SIJ and full spine were performed in both groups with identical protocol. **Central reading:** An experienced reader (AM) centrally read all MRI scans, blinded for clinical diagnosis. **Statistical analysis:** Sensitivity, specificity and positive likelihood ratio of each lesion were calculated.

Results: A total of 98 patients with recent onset CBP were included, and compared to 100 recent onset axSpA patients. Age and gender were comparable (mean (SD) 36.2 (9.9) vs. 32.2 (8.7)y, and 41.8% and 45% males, in the CBP vs. axSpA groups, respectively). MRI inflammatory lesions of the SIJ were quite frequent in the CBP group (25% patients with at least one inflammatory lesion) but were significantly more frequently observed in the axSpA group (table 1), with a mean SIJ - SPARCC score of 4.9 (8.8) vs. 0.6 (1.3), p<0.001. The ASAS definition of MRI sacroiliitis presented a high specificity and a good positive likelihood ratio. Conversely, prevalence of inflammatory lesions of the spine was very frequent in the CBP group and not significantly lower compared to the axSpA group (SPARCC spine 5.6 (13.5) vs. 3.3 (5.8), NS, in the axSpA vs. CBP groups, respectively). Regardless the definition of a positive MRI for the spine applied, performances were not good

Conclusions: ASAS definition of a positive MRI-sacroiliitis performed very well for axSpA recognition; however, definitions proposed for a positive MRI-spine suggestive of axSpA did not seem to perform adequately in this recent disease stage. This supports the idea of not including a positive MRI of the spine in the ASAS classification criteria.

Disclosure of Interest: None declared

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		CBP n=98	SpA n=100	p	Se	SpE	LR+
SIJ-MRI	At least one inflammatory lesion of the SIJ	24 (25.3%) n=95	40 (40.0%)	0.028	0.4 (0.3–0.5)	0.8 (0.7–0.8)	1.6 (1.0–2.4)
	ASAS definition of positive MRI sacroiliitis	8 (8.4%) n=95	35 (35.0%)	<0.001	0.4 (0.3–0.5)	0.9 (0.8–0.9)	4.2 (2.0–8.5)
Spine-MRI	At least one inflammatory lesions of the spine	44 (44.9%)	52 (52.5%) n=99	NS	0.5 (0.4–0.6)	0.6 (0.5–0.7)	1.2 (0.9–1.6)
	ASAS definition of positive MRI spine (≥3 inflammatory lesions)	33 (33.7%)	44 (44.4%) n=99	NS	0.4 (0.3–0.6)	0.7 (0.6–0.8)	1.4 (0.9–1.9)
	SPACE ⁽³⁾ definition of positive MRI spine (≥5 inflammatory lesions)	25 (25.5%)	30 (30.3%) n=99	NS	0.3 (0.2–0.4)	0.7 (0.7–0.8)	1.2 (0.8–1.9)