Abstract THU0242 – Table 1. Maternal disease activity and pregnancy outcomes in axSpA patients

Maternal axSpA disease activity during pregnancy and postpartum				
Study	Population[a]	Instrument	Activity during pregnancy[b]	Activity postpartum[c]
Ursin 2017[d]	axSpA: 181/168	BASDAI	Stable, low disease activity (2 nd trimester: BASDAI=3.97)	Stable, low disease activity (6 weeks pp: BASDAI=3.46)
Förger 2009[e]	AS[f]: 10	BASDAI	Moderate disease activity	Stable (2/10)
Förger 2005[e]	AS[g]: 10	BASDAI	Clinical improvement (4/10) 'Remained active' (6/10)	Not reported
van den Brandt 2017[e]	axSpA[g]: 37	ASDAS-CRP	'Persistent high activity'[h]	'Persistent high activity'[h]
Timur 2016[d]	AS[i]: 20	ASDAS-CRP	'Decreased score' (14/20) 'Unchanged score' (6/20)	'Decreased score' (2/20) 'Unchanged score' (3/20) 'Increased score' (15/20)
Pregnancy outcomes of axSpA patients and healthy controls				
Study	Populations[a]	Incidence per pregnancies vs controls (p value)		
Fang 2017[c][d]	AS: 2492	Preterm birth: 148/2492 vs 106/1412, 347,847 (aOR[95% CI]: 1.18 [1.00–1.38])	<0.05	
	Controls: 2,347,847	Birth weight <2500 g: 173/2492 vs 151,048/2,347,847 (aOR[95% CI]: 1.06 [0.91–1.22])	NS	
		SGA: 221/2492 vs 227,984/2,347,847 (aOR[95% CI]: 0.97 [0.85–1.11])	NS	
Förger 2017[c][d]	axSpA: 78/70	Preterm birth: 'higher risk'		
	Controls: 70	SGA: 'higher risk'		
Park 2017[c][d]	AS: 27/20	Preterm birth: Data not reported (NS)		
	Controls: 108	Low birth weight: 22.2% vs 8.3% (0.024)		
Timur 2016[d]	AS[j]: 20	Preterm birth: 3/20 vs 3/40 (0.390)		
	Controls: 40	Birth weight <2500 g: 5/20 vs 3/40 (0.150)		
Jakobsson 2016[k]	AS[l]: 199	Preterm birth: 22/199 vs 21/477 (aOR[95% CI]: 2.62 [1.27–5.39] for untreated patients; 1.79 [0.55–5.82] NS for NSAID-treated patients)		
	Controls: 477	SGA: 5/199 vs 6/477 (aOR[95% CI]: 0.37–4.85) NS for untreated patients; 4.47 [0.95–20.8] NS for NSAID-treated patients)		
Ostensen and Husby 1983[k]	AS[m]: 13	Preterm birth: 1/13 vs 0/31		
	Controls: 31	Miscarriage: 0/13 vs 1/31		

[a] Pregnancies/Women (if not equal); [b] Cases per total pregnancies (n/N); [c] Congress abstract; [d] Retrospective data; [e] Prospective data; [f] modified New York criteria; [g] ASAS classification criteria; [h] ASDAS-CRP: 2.1–3.5; [i] aOR [95% confidence interval]; [j] Crude odds ratio significant at 1.19 (1.03–1.38); [k] Case-control study; [l] ICD-10: M45. aOR: adjusted odds ratio; AS: ankylosing spondylitis; ASDAS-CRP: ankylosing spondylitis disease activity score-C-reactive protein; axSpA: axial spondyloarthritis; BASDAI: Bath ankylosing spondylitis disease activity index; NS: not significant; NSAID: non-steroidal anti-inflammatory drug; pp: postpartum; SGA: small-for-gestational-age.

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THU0243**CASE FATALITY OVER 365 DAYS AFTER FIRST ACUTE CORONARY SYNDROME IN PATIENTS WITH ANKYLOSING SPONDYLITIS**

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Background: Ankylosing spondylitis (AS) is characterised by systemic and local inflammation of the axial skeleton, joints, and entheses. Studies have suggested a higher risk of acute coronary syndrome (ACS) among patients with AS compared with the general population, but whether patients with AS also have an increased fatality following ACS is not known.

Objectives: Is AS associated with an increased case fatality after a first-time ACS compared with the general population?

Abstract THU0243 – Table 1. Mortality and hazard ratios (HR) for patients with AS and general population referents during 365 days of follow up after a first ACS

	Start		At 30 days follow up		At 365 days follow up		
	Individuals at risk	Individuals at risk	n deaths	HR (95% CI) day 0–30	Individuals at risk	n deaths	HR (95% CI) day 31–365
AS	292	273	26	0.9 (0.6;1.5)	266	56	2.0 (1.3;3.1)
General population comparator	1276	1204	118	ref	1158	184	ref

Methods: From the Swedish National Patient Register (NPR) we identified all patients registered with AS Jan 2001 through Dec 2014 and a later registration of a first time ACS between Jan 2006 and Dec 2014 (n=292). As a general population comparator, we identified up to 5 individuals per index-patient (n=1276), matched on year of first ACS and birth, gender, and place of living. The follow-up period began at the date of admission for ACS and extended until death, emigration, 365 days of follow-up or 31 December 2014, whichever occurred first. Hazard ratios (HR) for death in the AS group vs. the general population comparator was assessed using Cox regression. We assessed HRs for death in two intervals: 30 day mortality (day 1 through 30), and mortality day 31 through 365.

Results: During the 365 days following the ACS, 56 (19%) of the 292 AS patients and 184 (14%) of the 1276 population controls died (table 1). Whereas the 30 day mortality in the AS group was not elevated (HR=0.9), the mortality day 31 through 365 was doubled compared with the general population (HR=2.2, table 1 and figure 1).

Abstract THU0243 – Figure 1. Kaplan-Meier curves showing survival after first ACS in patients with AS and general population referents during 365 days follow up.

Conclusions: Patients with AS were at increased risk of death during the first year, though not during the first month, following ACS. It is yet not clear whether this could be due to factors associated with the AS disease *per se*, or differences in ACS characteristics or treatment.

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THU0244**HIGH PREVALENCE OF CLINICAL SPONDYLOARTHRITIS FEATURES IN PATIENTS WITH HIDRADENITIS SUPPURATIVA**

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Background: Hidradenitis suppurativa (HS) is a chronic debilitating inflammatory skin disease and is associated with several comorbidities. HS and spondyloarthritis (SpA) share several pathophysiological and clinical features, such as elevated cytokine levels of TNF- α and IL-17 and the association with inflammatory bowel