THU0267 GASTROINTESTINAL INVOLVEMENT IN SPONDYLOARTHRITIS IS NOT ALL IBD: INCREASED RISK OF DIVERTICULITIS WITH LONGER DISEASE DURATION IN THE ASAS-COMOSPA COHORT

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Background: Inflammatory bowel disease (IBD) is an established extra-articular manifestation of Spondyloarthritis (SpA). The association of SpA with other gastrointestinal and hepatic comorbidities is less well known.
Objectives: To examine the relationship between SpA disease duration and gastrointestinal comorbidities other than IBD.
Methods: ASAS-COMOSPA is a large global cross-sectional study comprising 3984 patients with SpA. We evaluated the association between "SpA disease duration" (defined in 5 year blocks) and upper gastrointestinal ulcers, hepatitis B (HBV), hepatitis C (HCV) and diverticulitis. Binary logistic regression models were created, adjusted for age, sex, BMI, smoking, alcohol, NSAIDs, DMARDs, biologics, steroids and IBD history. Subgroup analysis was performed, stratified by peripheral and/or axial joint involvement.
Results: The data of 3923 patients (64.9% male) were available for analysis, 5.3% of whom had a history of IBD. The self-reported prevalence of other gastrointestinal conditions was: upper gastrointestinal ulcers 10.7%; viral hepatitis 4.7% and diverticulitis 1.5%, with significant geographic variation. "SpA disease duration" was not associated with the occurrence of the upper gastrointestinal ulcers (OR=0.98, 95% CI: 0.92–1.05), HBV (OR=0.43, 95% CI: 0.28–0.67) or HCV (OR=0.27, 95% CI: 0.11–0.62). In contrast, the risk of diverticulitis was significantly increased by "SpA disease duration" (OR=1.14, 95% CI: 1.01–1.29); increased risk of 14% for every 5 years of disease duration) across the entire cohort, after adjustment for potential confounders, including age. Confounding variables showing significant association with diverticulitis were current age (OR=1.06, 95% CI: 1.04–1.08) and high alcohol (³3 units/day) intake (OR=3.84, 95% CI: 1.62–9.07) but not medication history (table 1). Subgroup analyses revealed stronger association of SpA disease duration with diverticulitis in those with axial (OR=1.24, 95% CI: 1.08–1.42) than those with peripheral (OR=1.12, 95% CI: 0.98–1.29) SpA disease.

Abstract THU0267 – Table 1. Association between diverticulitis and SpA disease duration

	p value	OR	95% CI for OR
SpA Disease Duration (5 y blocks)	**0.032**	**1.14**	**1.01–1.29**
Delay in SpA Diagnosis	0.477	1.01	0.98–1.04
Age (year)	<0.001	1.06	1.04–1.08
Gender (ref: Female)	0.062	0.57	0.31–1.03
Current BMI	0.965	1.00	0.95–1.05
Smoking (pack-year)	0.354	1.01	0.99–1.02
Alcohol (ref: Never)	0.022		
Ex-drinker	0.731	1.25	0.35–4.51
Current,<3 Units	0.132	1.66	0.86–3.23
Current, ³3 Units	0.002	3.84	1.62–9.07
Ever use of NSAIDs	0.816	0.90	0.37–2.21
Ever use of Steroids	0.380	1.30	0.73–2.31
Ever use of DMARDs	0.805	0.93	0.51–1.69
Ever use of Biologics	0.613	1.16	0.66–2.04
History of IBD	0.904	1.07	0.37–3.12

Conclusions: Patients with SpA have a number of gastrointestinal comorbidities, including increased risk of diverticulitis with increased SpA disease duration, highest in those with axial disease. The reasons for this association are unclear and warrant further investigation. Diverticulitis should be considered, in addition to IBD, when patients with SpA present with lower gastrointestinal symptoms.
Disclosure of Interest: None declared
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THU0268 THE FREQUENCY OF JUVENILE SPONDYLOARTHROPATHIES IN CHILDHOOD FAMILLIAL MEDITERRANEAN FEVER

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Background: Familial Mediterranean fever (FMF) is the most common monogenic autoinflammatory disease characterised with fever, recurrent episodes of self-limiting polyserositis and arthritis. FMF arthritis is generally acute monoarthritis especially in the larger joints of the lower extremities, healing without a sequelae. However some of the patients develop different type of chronic arthritis, predominantly oligoarticular juvenile idiopathic arthritis (JIA) and juvenile pondyloarthropathies (JSpA). Studies on JSpA among childhood FMF patients are spare.
Objectives: To evaluate frequency of JSpA in a large childhood FMF cohort. Furthermore, we aimed to define main characteristics of JSpA among childhood FMF patients.
Methods: A total of 320 juvenile FMF patients were blindly questioned according to recently proposed criteria for JSpA by 3 researchers (EO, DS, ET) that were previously educated for FMF and JSpA. A standardised case report form was prepared and completed for each patient. This form was including demographic data, clinical features, MEFV mutation and treatment. Patients fulfilled the JSpA criteria and were classified as probable JSpA. Afterwards, an expert in paediatric rheumatology (OK) reevaluated the classified patients and some of them were confirmed to be a definite while some of them were accepted as potential JSpA patients.
Results: As a result, 37 patients (11.5%) were initially classified as potential JSpA. Furthermore, 32 (10%) of them were accepted as definite and 5 (1.5%) patients as probable JSpA in childhood FMF. Demographic, clinical and treatment data of definitive JSPA patients are shown in Table **I.** The most frequent MEFV mutation among JSPA patients was M694V (63.33%).

Table I. Demographic, clinical and genetic features of childhood FMF patients.

	FMF + Definite JSPA	FMF + Probable JSPA	FMF patients without JIA and JSpA	FMF+JIA (except ERA or JSpA)
Patients, n	32	5	268	15
Female, n (%)	10 (31.25%)	1 (20%)	148 (55.22%)	10 (66.66%)
Age of disease onset, mean±SD years	7.19 ±3.68	5.60 ±4.93	4.91±3.40	4.93±3.32
Age at study, mean ±SD years	14.84 ±3.70	13.40 ±1.67	12.51±4.43	10.73±3.57
Family History of FMF, n (%)	15 (46.87%)	1 (20%)	132 (49.25%)	6 (40%)
Colchicine resistance in FMF patients, n(%)	2 (6.25%)	0	14 (5.22%)	1 (6.66%)
M694V mutation n(%)	19/30 (63.33%)	3 (60%)	148/245 (60.40%)	11 (73.33%)
Homozygote, n(%)	2	51 (34.45%)	8 (72.72%)	
Heterozygote, n(%)	7	(66.66%)	54 (36.48%)	2 (18.18%)
Compound heterozygote, n(%)	(36.84%) 5 (26.31%)	1	43 (29.05%)	1 (9.09%)
NA, n(%)	7 (36.84%) 2 (6.25%)	(33.33%) 0 0	23 (8.58%)	0
Disease onset over 6 years, n (%) years	26 (81.25%)	5 (100%)		6 (40%)
Oligorthritis, n(%)	21 (65.62%)	1 (20%)		14 (93.33%)
Inflammatory back pain, n(%)	17/32 (53.12%)	3/5 (60%)		0
Enthesopathy	22/32 (68.75%)	3/5 (60%)		0
Sacroiliitis	14/21 (66.66%)	0/1 (0)		0/5 (0)

Conclusions: Articular involvement compatible with JSpA could be seen in childhood FMF patients. Spondyloarthropathy was detected in 10% of childhood FMF cases. The M694V mutation is the most common MEFV mutation among JSpA patients with FMF. JSpA should be considered in childhood FMF patients, especially in those chronic arthritis, axial involvement and enthesopathy.

REFERENCE:

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