95% confidence intervals. Weights were calculated in each of the sampling stages in accordance with the probability of selection. The distribution of population in Spain obtained from the National Statistics Institute was taken into account.

Results: 4916 subjects were included in the study. 4753 completed their participation. Prevalence of rheumatic diseases were the following: The negative predictive value (NPV) of the initial screening questionnaire was 93.8%. The lower NPV corresponded to knee osteoarthritis (95.1%).

Conclusions: Prevalence of RA, PsA, AS, gout and SLE seems to be higher than previously published in other European countries.

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THU0685 CARDIOVASCULAR RISK ESTIMATION IN SLE PATIENTS: A COMPARISON OF THREE ALGORITHMS

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Background: Cardiovascular (CV) disease is a major cause of mortality and morbidity in SLE patients; several instruments have been developed to estimate the 10 years risk of major CV events in the general population according to the presence of traditional CV risk factors. However, it is well known that traditional CV risk factors cannot fully explain the increased CV disease in SLE. Recently, a new version of the Qrisk algorithm was released (QRISK3) incorporating new variables associated with increased risk of CV disease, including SLE diagnosis and the GC use.

Objectives: To assess the 10 years CV risk in a cohort of SLE patients by comparing three different algorithms.

Methods: Consecutive patients with a diagnosis of SLE according to the ACR criteria were recruited from the inpatients and outpatients clinics of our Unit. Previous major CV events (myocardial infarction and stroke) were considered exclusion criteria. Traditional CV risk factors, disease activity and damage as well as therapies and comorbidities were evaluated. Disease activity was assessed with the SLEDAI score, organ damage with the SLICC/DI. Three algorithms to estimate the 10 years risk of major events were applied: the Framingham score, the ACC/AHA score and the QRISK3. This latter incorporates new variables associated with increased risk of cardiovascular disease, including SLE and GC use.

Abstract THU0685 – Table 1

Cumulative organ involvement (%)	
Renal	45%
Articular	75%
Hematological	52%
Cutaneous	52%
Neuropsychiatric	10%
Serositis	20%
Ongoing therapies (%)	
Antimalarials	80%
Glucocorticoids	60%
Immunosuppressants	45%
Traditional CV risk factors (%)	
BMI > 30	5.8%
BMI > 25	12.5%
Sedentary life style	46%
Hypertension	33%
Diabetes	4%
Family history of CV events	15%
Actual smoking	20%
Dyslipidemia	35%
Metabolic syndrome	12%

Results: 115 SLE patients (90.5%) without previous major CV events were included in this analysis. They were predominantly females (93%), Caucasian (96.5%) with a mean age at enrollment of 42.8±12.5 and a mean disease duration

of 13.4±9.2 years. The prevalence of organ involvement and traditional risk factors are reported in table 1. Disease activity at enrollment was low (median SLEDAI 2, IQR 0–4) while 39.1% was presenting at least one organ damage.

The median Framingham risk score resulted 4.5% (IQR 2.4–8.6), the ACC/AHA resulted 1.2% (0.5–3.2), the QRISK3 resulted 5.4% (2.4–9.6). According to the three methods, there was a significant difference in the risk stratification: 10% of patients at medium-high CV risk according to the Framingham score, 5% with the ACC/AHA score and 21% with the QRISK3. The median “healthy heart age” of our cohort (the age at which a healthy subject has the same CV risk) provided by the QRISK3 resulted 62 years.^{52–68}

Conclusions: These data show that by applying the QRISK3 algorithm a significant percentage of patients would be reclassified at high risk of CV events with respect to the traditional CV risk scores. Longitudinal data are necessary to validate the QRISK3 accuracy against the traditional scores in the identification of SLE patients at higher risk of CV events.

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THU0686 CHANGES IN HEALTH-RELATED QUALITY OF LIFE OVER 5 TO 8 YEARS IN 1347 PATIENTS WITH EARLY ARTHRITIS OR EARLY INFLAMMATORY BACK PAIN

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Background: Health-related quality of life (HRQoL) is a priority for patients.

Objectives: The objectives were to describe the changes in HRQoL over 5–8 years in patients with early arthritis (EA) or early inflammatory back pain (IBP), and to explore factors associated with HRQoL.

Methods: In 2 prospective observational French cohorts (ESPOIR for EA patients and DESIR for early IBP patients), HRQoL was assessed every 6 months during the first 24 months and then every year over 5–8 years, using the SF36 physical composite score (PCS) and mental composite score (MCS) (range 0–100, US population norm: 50). Disease activity was assessed by DAS28-ESR and ASDAS-CRP. Univariate and multivariate linear mixed-effect models, and trajectory-based mapping (k-means) were applied.

Figure: Evolution of SF36-MCS and PCS over follow-up in EA and early IBP

Lines represent changes of mean SF36-MCS and mean SF36-PCS for EA and IBP; 95% confidence intervals were not represented because they were very small. The number of available data is between 696 and 508 according to the timepoint for SF-36 in EA and 646 to 422 according to the timepoint for SF-36 in IBP.

Figure 1 Evolution of SF36-MCS and PCS over follow-up in EA and early IBP

Results: In all, 1 347 patients (701 EA and 646 early IBP) were analysed: mean age 48.4±12.2 and 33.9±8.7 years respectively; mean disease duration 3.4±1.7 and 18.2±10.8 months, 76.3% and 55.0% females. At baseline, in EA, mean PCS and MCS were respectively 40.2±9.1 and 40.4±11.2, and in early IBP respectively 38.5±8.5 and 39.8±10.9. Over follow-up, HRQoL mean levels and trajectories improved mostly over the first 6 months (p<0.001). Overall, 54%–61% of patients reached levels of HRQoL close to population norms. DAS28-ESR and ASDAS-CRP over time were related to PCS (range of explained variance: 9% >43%, p<0.001 in the mixed models) but not to MCS.