Conclusions: Psychological stress was not increased in the phase of arthralgia, raised at the time of diagnoses and decreased thereafter. This temporal-relationship, and the lack of association with inflammation in arthralgia, argue against psychological stress having a significant contribution to inflammatory arthritis development.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3278

FRI0093 DON'T MISS THE DEPRESSION! COMORBIDITIES IN PATIENTS WITH RHEUMATOID ARTHRITIS AND THEIR IMPACT ON PATIENT-REPORTED OUTCOMES: RESULTS OF CLAIMS DATA LINKED TO A QUESTIONNAIRE SURVEY

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Background: Comorbidities are increasingly acknowledged as important clinical manifestation in patients with rheumatoid arthritis (RA).

Objectives: To investigate the prevalence of comorbidities in RA and their association with patient-reported outcomes.

Methods: Data of 96 921 persons with RA and 4 84 605 age- and sex-matched controls of a German statutory health fund were studied on the presence of selected comorbidities in 2015. Diagnoses and therapies were assigned to the provider (general practitioner, rheumatologist or another specialist). A self-reported questionnaire, comprising joint counts (TJC, SJC), functional status (FFbH), impact of the disease (RAID) and well-being (WHO-5) was sent to a random sample of 6195 persons with RA of whom 3184 responded. For respondents who confirmed their RA (n=2,535), the association between comorbidities and patient-reported outcomes were analysed by multivariable linear regression analyses.

Results: Compared to controls, persons with RA (mean age 63 years, 80% female) had higher prevalences of all comorbidities, the most common were depression and osteoporosis besides cardiovascular risk factors (table 1). The diagnosis of depression was provided in 50% of cases by general practitioners, in 13% by rheumatologists and in 48% by other specialists while the diagnosis of osteoporosis was made in 76% by general practitioners, in 48% by rheumatologists and in 46% by other specialists. Among the survey respondents, increasing numbers of comorbidities were associated with worse TJC, SJC, function and WHO-5 values. Depression, obesity and osteoporosis had the highest impact on functional status and TJC. The percentage of patients in rheumatologic care decreased from 73% with 0–1 comorbidity to 62% with ≥8 comorbidities (age-adjusted).

Abstract FRI0093 – Table 1. Prevalence of selected comorbidities in cases and controls

	RA patients n=96 921 % (95% CI)	Controls n=4 84 605 % (95% CI)
Cardiovascular risk factors		
Hypertension	61.8 (61.5–62.1)	48.0 (47.8–48.1)
Hyperlipidemia	39.4 (39.1–39.7)	32.4 (32.2–32.5)
Obesity	17.7 (17.5–18.0)	12.3 (12.2–12.3)
Comorbid disorders		
Depression	31.4 (31.1–31.7)	20.4 (20.3–20.5)
Osteoporosis	25.7 (25.4–26.0)	9.7 (9.6–9.8)
Diabetes	21.5 (21.2–21.7)	15.3 (15.2–15.4)
Cardiac arrhythmia	18.8 (18.5–19.0)	13.2 (13.1–13.3)
Hypothyroidism	17.9 (17.6–18.1)	12.8 (12.7–12.9)
Coronary heart disease	15.2 (15.0–15.4)	9.6 (9.5–9.7)
Liver disease	13.8 (13.6–14.0)	9.1 (9.0–9.1)
Vascular diseases	12.9 (12.7–13.1)	8.5 (8.4–8.6)
Asthma	12.3 (12.1–12.5)	7.4 (7.3–7.4)
COPD	11.3 (11.0–11.4)	6.6 (6.5–6.6)

Conclusions: Osteoporosis and depression are amongst the most common disorders in persons with RA. While osteoporosis is usually taken into account by the rheumatologist, more attention should be paid to depression as both disorders strongly affect patient-reported outcomes.

Acknowledgements: This study was funded by the German Federal Ministry of Education and Research (01EC1405).

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2399

FRI0094

DOES SUBCLINICAL INFLAMMATION EXPLAIN JOINT PAIN IN PATIENTS WITH ARTHRALGIA SUSPICIOUS FOR PROGRESSION TO RHEUMATOID ARTHRITIS? – RESULTS OF A CROSS-SECTIONAL MRI-STUDY

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Background: The development of Rheumatoid Arthritis (RA) is often preceded by a symptomatic phase of arthralgia. The etiology of symptoms in this phase is unclear.

Objectives: Since subclinical joint inflammation is expected to be causally related to pain, we aimed to determine associations between subclinical MRI-detected inflammation and pain in patients with arthralgia suspicious for progression to RA.

Methods: Unilateral MRIs of the wrist, MCP(2–5)- and MTP(1–5)-joints of 325 patients who fulfilled the EULAR definition of arthralgia suspicious for progression to RA were made and scored by two readers on subclinical inflammation (synovitis, bone marrow oedema (BME) and tenosynovitis). Associations between MRI-detected inflammation and overall pain severity at patient level (measured using the visual analogue scale (VAS)), and local tenderness at joint palpation, were studied in all patients, in ACPA-positive and ACPA-negative patients separately, and in the subgroup of patients that progressed to inflammatory arthritis.

Results: At patient level, synovitis ($\beta=0.10$, $p=0.048$) and tenosynovitis ($\beta=0.11$, $p=0.026$) associated with the VAS-pain. Of the 1620 imaged joints, 447 (28%) were tender. Subclinical inflammation was present in 32% of tender joints and in 25% of non-tender joints. MRI-detected synovitis associated independently with joint tenderness (OR 1.74, $p<0.001$). In ACPA-negative patients synovitis associated independently with joint tenderness (OR 1.96, $p<0.001$), while BME was independently associated with joint tenderness in ACPA-positive patients (OR 2.39, $p=0.005$). Sensitivity analyses in patients who developed arthritis during follow-up ($n=61$) revealed similar associations.

Conclusions: In patients with arthralgia suspicious for progression to RA, joint tenderness and pain are associated with MRI-detected subclinical inflammation. The association is incomplete, indicating that subclinical inflammation is not the sole explanation of the arthralgia.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3294

FRI0095

ANTI-TNFA VERSUS RITUXIMAB IN REFRACTORY PERIPHERAL ULCERATIVE KERATITIS ASSOCIATED TO RHEUMATIC DISEASES. MULTICENTER STUDY OF 24 PATIENTS

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Background: This study shows that treatment with biologic drugs, including anti-TNF drugs, in NION associated to IMIDs, refractory to conventional treatment, seems to be effective. These results must be confirmed in prospective and randomised trials.

Objectives: Our aim was to compare anti-TNF α vs Rituximab (RTX) in refractory PUK.

Methods: Multicenter study of 24 patients with PUK. All of them presented inadequate response to corticosteroids and at least 1 systemic traditional immunosuppressive drug.

Anti-TNF α were used in 17 patients: Adalimumab ($n=9$) 40 mg/sc every 1–2 weeks, infliximab (IFX) ($n=7$) 3–5 mg/kg iv/4–6 weeks, etanercept ($n=1$) 50 mg/week. RTX was used in 7 patients 1–2 g i.v. every 6 or 12 months.

The main outcomes were Best Corrected Visual Acuity (BCVA), signs of inflammation (scleritis and episcleritis), progression to corneal thinning, central keratolysis and ocular perforation.