Abstract FRI0180 – Figure 1. Most common first symptom to prompt seeking care (A) and most common misdiagnoses (B) in patients with AS

Conclusions: The diagnostic process differs among males and females with AS. Our study findings highlight gender differences in initial symptom presentation, misdiagnoses, and time to diagnosis of AS.

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FRI0181 TWELVE YEARS FOLLOW-UP OF PATIENTS WITH SPONDYLOARTHRITIS IN AN ENDEMIC CITY DEMONSTRATES HIGH RISK OF ACTIVE TUBERCULOSIS INFECTION

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Background: Anti-tumour necrosis factor (anti-TNF) agents can induce progression from latent tuberculosis infection (LTBI) to active tuberculosis (TB) in patient with rheumatic diseases^{1,2}. In a high tuberculosis incidence setting, TB cases developed despite the screening and treatment for LTBI.

Objectives: To identify, in a high TB incidence setting, the TB incidence rate in patients with spondyloarthritis (SpA) during twelve years of follow-up.

Methods: Electronic medical records from patients attending the SpA Clinic between 2004 and 2016 in a public university hospital were reviewed. Patients were grouped in those exposed to anti-TNF therapy and those non-exposed. The tuberculosis incidence rate (IR) was calculated for both groups and expressed as number of events per 1 00 000 patients/year; the incidence rate ratio (IRR) associated to the anti-TNF therapy was calculated.

Results: A total of 274 patients were evaluated, 102 exposed to anti-TNF drugs and 172 non-exposed. All the 102 patients underwent screening for LTBI before anti-TNF therapy: 38.2% (n=39) were diagnosed with LTBI and underwent 6 months of isoniazid preventive therapy (IPT). The total follow up time (in patients/year) was 729 in the group exposed to anti-TNF and 1243 in the group non-exposed. Ten patients were diagnosed with TB: 4 exposed to anti-TNF therapy and 6 non-exposed. Among the 4 patients exposed to anti-TNF therapy who developed TB, three had negative screening for LTBI. The TB IR (per 1 00 000 patients/year) among those exposed to anti-TNF was 548, compared to 321 in non-exposed; the IRR associated with the use of anti-TNF drugs was 1.7.

Conclusions: In a region with high TB prevalence, patients with SpA exposed to anti-TNF drugs had a higher incidence of TB compared to those who have never been exposed to these drugs. Our data reinforces the American College of Rheumatology's recommendation that patients who live in endemic TB settings should be tested annually for LTBI.

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		CBP n=98	SpA n=100	p	Se	Spe	LR+
MRI SIJ							
N(%) patients with at least one structural lesion		16/95 (16.8%)	24 (24%)	NS	0.2 (0.2–0.3)	0.8 (0.7,0.0)	1.4 (0.8–2.5)
N(%) patients with ≥3 subchondral bone erosions		10/95 (10.5%)	32 (32%) <0.001	0.32 (0.2–0.4)	0.9 (0.8–1.0)	3.0 (1.6–5.8)	
N(%) patients with ≥3 subchondral bone fatty lesions		11/95 (11.6%)	29 (29%) 0.004	0.29 (0.2–0.4)	0.88 (0.8–0.9)	2.5 (1.3–4.7)	
N(%) patients with ≥5 subchondral bone erosions or fatty lesions		13/95 (13.7%)	33 (33%) 0.002	0.33 (0.2–0.4)	0.9 (0.8–0.9)	2.4 (1.4–4.3)	
MRI spine							
N(%) patients with at least one structural lesion		49 (50.0%)	42/99 (42.4%)	NS	0.4 (0.3–0.5)	0.5 (0.4–0.6)	0.8 (0.6–1.2)
N(%) patients with ≥3 subchondral bone erosions		6 (6.1%)	7/99 (7.1%)	NS	0.1 (0.0–0.1)	0.9 (0.9–1.0)	1.2 (0.4–3.3)
N(%) patients with ≥3 subchondral bone fatty lesions		21 (21.4%)	15/99 (15.2%)	NS	0.2 (0.1–0.2)	0.8 (0.7–0.9)	0.7 (0.4–1.23)
N(%) patients with ≥5 subchondral bone fatty lesions		8 (8.2%)	21/99 (21.2%)	0.02	0.2 (0.1,0.3)	0.9 (0.8–0.9)	2.5 (1.2–5.4)
N(%) patients with ≥5 subchondral bone erosions OR fatty lesions		19 (19.4%)	11/99 (11.1%)	NS	0.1 (0.1–0.2)	0.8 (0.7–0.9)	0.6 (0.3–1.1)