arthritis (RA). Previous prospective studies have used a clinical definition of arthritis. Thus, we aimed to investigate risk factors of developing arthritis in ACPA-positive subjects with musculoskeletal complaints who did not have any of clinical and ultrasound signs of arthritis.

Methods Subjects with positive ACPA-test referred from primary care to rheumatology clinic, lacking arthritis in hands and feet by clinical and ultrasound examination (according to EULAR-OMERACT synovitis definition), were recruited into the Risk-RA research program. Patient included between years 2015–2016 with clinical data up to 2017 were analysed. Blood samples from inclusion were analysed for 13 specific ACPA reactivities using a custom made ImmunoCAP ISAC microarray. Presences of HLA-SE risk gene were analysed using DR low-resolution kit.

Results 41% (27 out of 66) of the Risk RA subjects developed arthritis during a median follow up of 8 months. The rest was followed 25 months in median without any signs of arthritis. Subjects developing arthritis tended to have a higher concentration of anti-CCP, more tender joints and rheumatoid factor positivity at inclusion compared to those not developing arthritis. The number of ACPA-reactivities (mean 6 vs 3), the presence of HLA-SE (89% vs 56%) and the occurrence of ultrasound detected tenosynovitis (44% vs 5%) at inclusion were significantly increased in subjects developing arthritis compared to those not developing arthritis.

Univariate cox proportional hazards regression showed a hazard ratio (HR) for arthritis development of 1.1 for every increase in number of ACPA reactivities (95% CI 0.99 to 1.2, p 0.07); HR: 4.4 (95% CI 2.0 to 9.5, p 0.0002) for tenosynovitis and for HR: 4.9 (95% CI 1.5 to 16, p 0.01) for HLA-SE carriers. All subjects with tenosynovitis ($n=14$) prior to arthritis development were carriers of HLA-SE, except for one subject but similar to the majority this HLA-SE no-carrier also progressed to arthritis.

Conclusions Subjects with ACPA-positive musculoskeletal complaints lacking any clinical and ultrasound signs of arthritis are at high risk of developing arthritis, especially carriers of HLA-SE with tenosynovitis. The role of inflammatory spreading from tendons (synovial sheath) to synovial tissue within joints need to be further investigated.

Disclosure of Interest None declared

P024 DISTURBED SEXUAL FUNCTIONING IN FEMALE PATIENTS WITH IDIOPATHIC INFLAMMATORY MYOPATHIES

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10.1136/annrheumdis-2018-EWRR2019.18

Career situation of first and presenting author Student for a master or a PhD.

Introduction Idiopathic inflammatory myopathies (IIM) are characterized by inflammation and atrophy of skeletal muscles, pulmonary and articular involvement, which leads to functional impairment, reduced quality of life including sexual life.

Objectives The aim of this study was to assess sexual functions/quality of life and pelvic floor function in female IIM patients compared to age-/sex-matched healthy controls (HC).

Methods In total, 22 women with IIM [mean age: 55.1, disease duration: 7.9 years, dermatomyositis (DM, 8)/polymyositis

(PM, 10)/necrotizing myopathy (IMNM, 3)/inclusion body myositis (IBM, 1)], who fulfilled the Bohan/Peter 1975 criteria for DM/PM, and 22 healthy controls (mean age: 55.1 years) filled in 12 well-established and validated questionnaires assessing sexual function and pelvic floor function, fatigue, physical activity and depression. We used the following questionnaires: Female Sexual Function Index (FSFI), Brief Index of Sexual Function for Women (BISF-W), Sexual Quality of Life Questionnaire (SQoL-F), Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12), Pelvic Floor Distress Inventory Questionnaire (PFIQ7), Fatigue Impact Scale (FIS), Beck's Depression Inventory II (BDI II), Health Assessment Questionnaire (HAQ) and Human Activity Profile (HAP).

Results Compared to HC, patients with IIM had significantly higher prevalence and greater severity of sexual dysfunction (FSFI, BISF-W: in all subscales as well as total scores), dysfunction of pelvic floor (PISQ-12), and worse sexual quality of life (SQoL-F). Worse scores in IIM patients were associated with elevated muscle enzyme levels [lactate dehydrogenase: FSFI ($r=-0.524$, $p=0.0123$), BISFW ($r=-0.528$, $p=0.0115$)], greater fatigue [FIS: FSFI ($r=-0.434$, $p=0.0438$), BISF-W ($r=-0.488$, $p=0.0211$), SQoL-F ($r=-0.488$, $p=0.0070$), PISQ-12 ($r=0.643$, $p=0.0013$)], more severe depression [BDI-II: PISQ-12 ($r=0.474$, $p=0.0258$)], deteriorated quality of life [HAQ: PISQ-12 ($r=0.476$, $p=0.0252$)], and worse ability to perform physical activities [HAP: FSFI ($r=0.437$, $p=0.0417$), BISF-W ($r=0.451$, $p=0.0351$), PISQ-12 ($r=-0.494$, $p=0.0195$)].

Conclusions Women with IIM reported significantly disturbed sexual function, sexual quality of life and pelvic floor function than age-matched healthy controls. Worse scores in IIM were associated with disease activity, physical activity, fatigue, depression and quality of life.

Acknowledgements Supported by AZV-16-33574A, MHCR 023728, and SVV – 2 60 373.

Disclosure of Interest None declared.

P025 DISTURBED SEXUAL FUNCTIONING IN FEMALE PATIENTS WITH SYSTEMIC SCLEROSIS

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10.1136/annrheumdis-2018-EWRR2019.19

Career situation of first and presenting author Student for a master or a PhD.

Introduction Systemic sclerosis (SSc) is a chronic autoimmune disease leading to various physical and psychological impairments including sexual dysfunction.

Objectives The aim of this study was to assess sexual functions/quality of life and pelvic floor function in female SSc patients compared to age-/sex-matched healthy controls (HC), and to analyze the potential impact of disease activity, fatigue, physical activity and depression.

Methods In total, 41 women with SSc (mean age: 50.9, disease duration: 5.8 years, lcSSc/dcSSc: 18/23, mRSS: 13.6, ESSG activity index: 2.5), who fulfilled the ACR/EULAR 2013 criteria, and 41 healthy controls (mean age: 50.9) without rheumatic diseases filled in 12 well-established and validated questionnaires assessing sexual function/quality of life, pelvic floor function, fatigue, physical activity and depression. We