effect of biologics on joint damage has not translated into a clear-cut decreased need for joint sacrificing surgery as observed in several RA populations.

After 15 years of follow-up, 29% of the PsA patients had received surgery.

Table 1. Incidence of any joint surgery and joint sacrificing surgery in each calendar period and calculated incidence rate ratios

Calendar period	Any joint surgeries, n (Joint sacrificing as first surgery, n)		Person years, pyrs		Incidence rate per 1000 pyrs (95% CI)		Incidence rate ratio (95% CI) comparing PsA with GPC as reference in each calendar period
	PsA	GPC	PsA	GPC	PsA	GPC	PsA vs GPC
1996 - 2000	145 (56)	536 (180)	7966	74092	18.2 (15.4-21.4)	7.2 (6.6-7.9)	2.4 (2.0-2.9)
2001 - 2004	160 (76)	643 (198)	7572	70850	21.1 (18.0-24.7)	9.1 (8.4-9.8)	2.3 (1.9-2.7)
2005 - 2008	264 (100)	1261 (389)	12128	115197	21.7 (19.2-24.6)	11.0 (10.4-11.6)	2.0 (1.7-2.3)
2009 - 2012	316 (122)	1536 (467)	14921	143524	21.1 (18.9-23.7)	10.7 (10.2-11.3)	2.0 (1.7-2.2)

Abbreviations: n, number. CI 95%, 95% confidence interval. Ref, reference.

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THE ASSOCIATION BETWEEN JOINT EROSIONS PLUS AUTOANTIBODY POSITIVITY AT INITIATION OF METHOTREXATE OR BIOLOGIC THERAPY FOR RHEUMATOID ARTHRITIS AND DISEASE ACTIVITY AND DISABILITY OVER ONE YEAR

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Background: Joint erosions and autoantibody positivity (rheumatoid factor [RF], anti-cyclic citrullinated peptide antibody [anti-CCP]) predict poor outcomes in patients with rheumatoid arthritis (RA). There are limited data on the combination of these factors and clinical and patient reported outcomes over time.

Objectives: To compare the disease activity and disability over 1 year of those with poor prognostic factors at treatment initiation (methotrexate [MTX] or biologics) to those without.

Methods: Patients were recruited to 1 of 2 UK-based multi-centre prospective cohort studies: MTX-starters: Rheumatoid Arthritis Medication Study (RAMS); biologic-starters: Biologics in Rheumatoid Arthritis Genetics and Genomics Study Syndicate (BRAGSS). Anti-CCP (Axis-Shield Anti-CCP test; U/ml; anti-CCP titre >5 U/ml = anti-CCP+/RF (Beckman

Coulter AU5400, RF latex assay; IU/ml; RF titre >14 IU/ml = RF+) status were determined from baseline (BL) blood samples at the co-ordinating centre; erosions (yes/no) were recorded from medical notes. Missing data resulting from anti-CCP assay failure were imputed using multiple imputation. Patients who were anti-CCP+ and/or RF+ and had erosions were classified as having poor prognosis (PP); all other patients were classified as not having poor prognosis (NPP). Patients completed the Health Assessment Questionnaire (HAQ) and the Disease Activity Score (DAS28) was calculated at BL, 6 months and 12 months. The DAS28 and HAQ scores of the prognostic groups were compared at each assessment using linear regression, adjusted for age, gender and disease duration.

Baseline characteristics of the PP and NPP patients in each cohort

Baseline characteristic	MTX-starters		Biologic-starters	
	PP	NPP	PP	NPP
N (%)	182 (15.4)	997 (84.6)	467 (40.5)	685 (59.5)
Age, years	61.5 (5.2, 70)	58 (48, 67)	59 (51, 67)	57 (49, 65)
Female, N (%)	116 (63.7)	647 (64.9)	344 (77.8)	516 (75.3)
Disease duration, months	16.5 (6, 46)	6 (4, 23)	132 (60, 240)	48 (24, 96)
Smoking:				
Never	68 (38.0)	390 (39.4)	146 (32.7)	233 (34.8)
Former	75 (41.9)	400 (40.4)	204 (45.7)	298 (44.5)
Current	36 (20.1)	199 (20.1)	96 (21.5)	139 (20.6)
Swollen joint count (28)	5 (2, 9)	4 (2, 9)	8 (6, 12)	8 (5, 11)
Tender joint count (28)	5 (2, 12)	6 (2, 12)	12 (9, 19)	15 (10, 20)
CRP, mg/l	7 (2, 21)	5 (2, 15)	10 (5, 25)	9 (4, 24)
DAS28	4.3 (3.4, 5.1)	4.1 (3.2, 5.1)	5.7 (5.2, 6.3)	5.8 (5.3, 6.3)
Health Assessment Questionnaire	1.00 (0.38, 1.63)	1.13 (0.50, 1.75)	1.75 (1.25, 2.13)	1.63 (1.25, 2.13)
Pain visual analogue scale	50 (29, 73)	48 (25, 70)	70 (55, 80)	69 (52, 79)
Fatigue visual analogue scale	51 (24, 75)	52 (25, 72)	75 (57, 85)	74 (55, 86)
Anti-CCP+, N (%)	139 (88.5)	405 (68.5)	193 (97.5)	226 (82.5)
Rheumatoid factor+, N (%)	170 (95.0)	489 (60.2)	410 (93.6)	367 (58.4)
Erosions, N (%)	182 (100)	46 (4.6)	467 (100)	20 (2.9)

Median (IQR) unless otherwise stated. Results from the first imputed dataset.

Anti-CCP = anti-cyclic citrullinated peptide antibody, DAS28 = Disease Activity Score (28), MTX = methotrexate, N = number, BL = poor prognosis group, PP = poor prognosis group

Results: In total, 1179 (PP = 182 [15.4%]) MTX-starters and 1152 (PP = 467 [40.5%]) biologic-starters were included (BL characteristics in Table). For MTX-starters, PP and NPP patients had similar DAS28, whereas for biologic-starters, PP patients had lower DAS28 compared to NPP patients after baseline (adjusted mean difference [95% CI]: MTX-starters BL = 0.1 [-0.1, 0.3]; 6 months = -0.1 [-0.3, 0.2]; 12 months = -0.1 [-0.4, 0.2]; biologic-starters BL = -0.1 [-0.2, 0.0]; 6 months = -0.2 [-0.4, 0.0]; 12 months = -0.4 [-0.6, -0.1]). HAQ scores were similar between PP and NPP patients in both cohorts (adjusted mean difference [95% CI]: MTX-starters BL = 0.08 [-0.04, 0.20]; 6 months = 0.02 [-0.11, 0.15]; 12 months = -0.03 [-0.17, 0.10]; biologic-starters BL = 0.00 [-0.09, 0.08]; 6 months = 0.00 [-0.12, 0.13]; 12 months = 0.01 [-0.14, 0.16]).

Conclusion: PP and NPP MTX-starters had similar outcomes. For biologic-starters, PP patients had lower disease activity after baseline; knowledge of these prognostic factors may have prompted more intensive assessment of PP patients after starting treatment.

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AUTOIMMUNE PERIPHERAL ULCERATIVE KERATITIS: ASSOCIATED ETIOLOGY, CLINICAL CHARACTERISTICS, TREATMENT AND VISUAL PROGNOSIS

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Background: Peripheral ulcerative keratitis (PUK), a rare sight-threatening condition, is an inflammatory corneal disease with an estimated incidence of 8 to 10 cases per million. PUK is characterized by the presence of an epithelial defect with progressive stromal corneal degradation and juxtalimbal thinning.

Objectives: To describe the associated etiology, demographic and clinical characteristics, treatment and visual prognosis of patients with PUK and autoimmune disease.

Methods: A retrospective, transversal, descriptive, observational cohort study was performed. The clinical file of all patients that had been diagnosed with PUK at the Inflammatory Eye Disease Clinic and who came to a follow-up appointment between January 2014 through February 2018 was evaluated. With a minimum follow-up of 6 months since PUK diagnosis.

Quantitative data was calculated in terms of means and standard deviations. Qualitative data in frequencies. Chi-square and rank sum tests were used to compare groups. Kaplan-Meier methods to estimate survival