ADA (n=11; 44%), IFX (n=6; 24%), UST (n=3; 12%), golimumab (n=3; 12%), SCK (n=1; 4%) and vedolizumab (n=1; 4%). The indication was intestinal in 4 patients, joint in 8 and both in 13.

The clinical and analytical evolution in all patients was satisfactory, with a mean ESR of $11.6 \pm 9 \text{ mm}^1 \text{h}$, CRP $0.6 \pm 0.3 \text{ mg/dL}$ and BASDAI 2 in the last control, after an average time of evolution of 12.5 ± 9.3 years.

Conclusion: In this series, IBD was observed in 9.26% of patients with SpA of which 64% were AS. The most frequent form was CD and it was diagnosed after SpA in 60% of the cases. 6 patients were with BT at the time of IBD onset. High FC ($> 200 \mu\text{g/g}$) was observed in the majority of patients.

Therefore, we recommend assessing the presence of digestive manifestations (abdominal pain, weight loss or diarrhea) in patients with SpA due to their possible association with IBD. The FC is a useful tool in these patients.

TABLE 1. CHARACTERISTICS OF IBD IN SpA SUBTYPES

	AS (n=16, 64%)	PsA (n=6, 24%)	uSpA (n=3, 12%)	TOTAL= 25
MEN/WOMEN	14/2	4/2	2/1	20/5 (80%/20%)
AGE AT IBD DX (average in years)	37.56	45.8	34	39.12
HLA B27* (n, patients)	13	1	1	15 (60%)
CD/UC (n, patients)	9/6/1	2/2/2	2/1/0	13/9/3 (52%/36%/12%)
ESR (average in $\text{mm}^1 \text{h}$)	30.07	39.75	21.5	31.15
CPR (average in mg/dL)	2.44	3.08	3.42	2.7
FC (average in $\mu\text{g/g}$) (24 patients with Jevon > 50 included)	369.2	409.67	1009	459.29
BEFORE / SIMUL / AFTER (IBD in relation to SpA DX)	6/2/8	0/0/6	1/1/1	7/3/15 (28%/12%/60%)
BT AT IBD DX (n, patients)	3	2	1	6 (24%)
BT	ETN (n=1), IFX (n=1), SCK (n=1)	ADA (n=1), UST (n=1)	ETN (n=1)	ETN (n=2), IFX (n=1), ADA (n=1), SCK (n=1), UST (n=1)

IBD: inflammatory bowel disease, AS: ankylosing spondylitis, PsA: psoriatic arthritis, uSpA: undifferentiated spondyloarthritis, CD: Crohn's disease, UC: ulcerative colitis, IC: indeterminate colitis, ESR: erythrocyte sedimentation rate, CPR: C-reactive protein, FC: fecal calprotectin, BEFORE/SIMUL/AFTER: before the diagnosis of SpA simultaneously/after, DX: diagnosis, BT: biological therapy, ETN: etanercept, ADA: adalimumab, IFX: infliximab, SCK: secukinumab, UST: ustekinumab

TABLE 2. BT IN 270 PATIENTS WITH SpA.

	Patients (n)	IBD development after BT (n)	IBD development after BT (%)
ETN	57	2	3.50%
ADA	98	1	1.02%
IFX	36	1	2.78%
SCK	22	1	4.54%
UST	15	1	6.67%
CZP	25	0	0%
GLM	15	0	0%
VDZ	2	0	0%
TOTAL	270	6	2.22%

BT: biological therapy, IBD: inflammatory bowel disease, ETN: etanercept, ADA: adalimumab, IFX: infliximab, SCK: secukinumab, UST: ustekinumab, CZP: certolizumab, GLM: golimumab, VDZ: vedolizumab

Disclosure of Interests: None declared

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SAT0321 CARDIOVASCULAR EVENTS IN SPONDYLOARTHRITIS : A META-ANALYSIS

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Background: Several studies have demonstrated the possibility of increased risk of cardiovascular disease in patients with inflammatory arthritis such as ankylosing spondylitis and rheumatoid arthritis. In recent years, studies using population -based cohort and insurance claim data have been actively conducted.

Objectives: To compare risks for cardiovascular disease including myocardial infarction (MI), ischemic heart disease (IHD), stroke and mortality of spondyloarthritis compared to general population using large-scale data.

Methods: A systematic search was performed in MEDLINE, EMBASE with additional manual searches for studies associated with spondyloarthritis published between January 1997 and October 2018. All search screening and data collection were performed independently by two reviewers. We calculated the incidences of MI, IHD, stroke and mortality in a meta-analysis of proportion and determined risk ration (RR) by Mante-Haenszel method.

Results: We identified total 495 articles and 16 articles met criteria for meta-analysis including 13 ankylosing spondylitis (AS) studies, 3 psoriatic arthritis (PsA) studies and 1 undifferentiated spondyloarthritis study. The articles were based on large-scale data such as national population cohort or insurance claim data. A meta-analysis result showed a significant increase in the risk of MI (RR= 1.38; 95% CI 1.18 to 1.61), and stroke (RR= 2.04; 95% CI 1.11 to 3.78) in spondyloarthritis patients compared to general population. However, mortality related with cardiovascular disease (RR=1.19; 95% CI 0.96 to 1.48) and total mortality (RR= 1.31; 95% CI 0.8 to 2.15) results did not show significant increases in spondyloarthritis patients.

Conclusion: Our meta-analysis results showed that the the risk of MI and stroke significantly increased although mortality associated with cardiovascular (CV) disease and overall mortality did not increase in spondyloarthritis compared to general population. These findings support the reduction of inflammation as well as the management of traditional cardiovascular disease risk factors may reduce CV risk in patients with spondyloarthritis.

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SAT0322

AXSPA PATIENTS WITH SYMPTOM ONSET <30 YEARS HAVE MORE STRUCTURAL LESIONS ON MRI OF THE SACROILIAC JOINTS WHEN FULFILLING THE MODIFIED NEW YORK CRITERIA

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Background: The modified New York criteria (mNY) combine clinical symptoms with radiographic sacroiliitis on conventional pelvic radiographs (X-SI) classifying radiographic axial SpA patients (r-axSpA). AxSpA is known to typically start in the third era of life but there is a diagnostic delay of ± 7 years. As the mNY criteria classify the most typical and severe expression of axSpA it is suggested that the mNY criteria are less useful in younger patients.

Objectives: To explore the diagnostic utility of the mNY criteria in newly diagnosed axSpA patients with a symptom onset <30 years. In addition, describe the extent of lesions on MRI of the sacroiliac joints (MRI-SI) in mNY positive (mNY+) patients with a symptom onset <30 years.

Methods: This study involved newly diagnosed axSpA patients, age ≥ 18 years, from a Belgian (Be-Giant) cohort. Patients underwent diagnostic tests involving clinical examination, lab tests, and imaging assessment containing an X-SI and an MRI-SI. mNY criteria was assessed on X-SI. MRI-SI reads contained the assessment of inflammatory lesions according to the Spondyloarthritis Research Consortium of Canada (SPARCC) scoring method and erosions, fatty lesions (FL), sclerosis, ankylosis using an adapted method of the SPARCC. Also, the ASAS definition of a positive MRI-SI was evaluated. T1-weighted and STIR images were viewed simultaneously. X-SI and MRI-SI were evaluated independently by 3 trained readers who were also blinded for clinical features. Imaging scores (X-SI grading according to the mNY criteria and mNY fulfillment, and MRI-SI lesion scores) were calculated as 2 out of 3 reader scores.

Results: In the 173 patients with available X-SI, the average age at symptom onset was 27.4 years old. In 114/173 (65.9%) patients, the symptom onset was below 30 years. Of those, 11 (9.6%) patients fulfilled the mNY criteria. Seven of the 11 (63.6%) patients that were mNY+ were male, which was slightly lower than in the mNY- patients (n=55; 53.4%). The presence of HLA-B27 was comparable between mNY+ and mNY- patients; 8 (72.7%) patients and 82 (79.6%) patients, respectively. Average X-SI grading in mNY+ patients was 4.7 ± 1.3 (on a scale from 0-8) and in mNY negative (mNY-) patients (n=103) the average X-SI grading was 1.1 ± 1.1 . When looking at the MRI-SI assessment, 8/11 mNY+