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SAT0341 THE PREVALENCE OF RENAL FAILURE IN A PROSPECTIVE AXIAL SPONDYLOARTHRITIS COHORT AND POSSIBLE ASSOCIATED FACTORS

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Background: Extra-articular manifestations and comorbidities are significant complications in the evolution of patients with spondyloarthritis (SpA). The presence of renal failure (RF) is a multifactorial comorbidity that has been shown to be associated with this disease, and its prevalence has been reported around 5% (COMOSPA¹). There are no prevalence studies in our environment.

Objectives: To determine the prevalence and possible factors associated with RF in patients with axial spondyloarthritis (axSpA).

Methods: Data was retrieved from a prospective database designed for the monitoring of patients with SpA from a large teaching hospital. We only included patients with axSpA. Demographic and clinical data were recorded, as well as possible risk factors associated with RF: arterial hypertension (AHT), smoking status, Diabetes (DM), Dyslipidemia (DL), NSAIDs use and renal function from last test available (we considered RF when eGFR<60 mL/min).

Continuous data were compared with Student t-test if the variables presented normal distribution (previous Shapiro-Wilk test) or Mann Whitney U test otherwise. Chi-square or Fisher test was performed if the variable was categorical.

Results: 339 patients were included. 73.2% were male with a mean age of 56.68 (±14.8) years and a mean age of onset of 32.0 (±11.4) years. The mean disease duration was 32.8 (±11.4) years. 83.7% were HLAB27+. The clinical variables for the whole cohort were: BASDAI 3.56 (±2.13), BASFI 3.74 (±2.65), CRP 5.61 (±6.92) and ESR 2.28 (±0.89). The following risk factors were registered: smokers 58.3%, AHT 33.3%, DL 31.3% and NSAID use of 34.6%. 27.4% of patients were receiving biologic therapy.

41 patients (12.1%) presented RF criteria. Comparison between two groups is shown in table 1. A statistically significant association with RF was found in age, sex, AHT, DL, no use of NSAIDs, higher BASFI and ASDAS indexes as well as ESR value.

Conclusion: There is a substantial prevalence of RF in patients with axSpA in our cohort. We should maximise our awareness of RF in old patients, those suffering from AHT and DLP, as well as subjects with high BASFI, ASDAS and ESR values.

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Table 1. Comparative analysis of patients with RF and recorded variables

Variables	RF (n=41)	No RF (n=298)	P-value
Age, mean (SD)	71.12 ± 7.8	54.64 ±14.52	<0.0001*
Male	87.8%	71.1%	0.024*
Arterial hypertension	82.9%	26.5%	<0.0001*
Dyslipidemia	46.3%	29.2%	0.026*
Diabetes Mellitus	19.5%	9.7%	0.103
BMI, mean (SD)	28.45 ± 5.72	26.36 ± 4.39	0.065
Smokers	69.7%	56.9%	0.159
HLA B27(+)	80%	84.2%	0.5
axSpA phenotype	100%	91.6%	0.056
- AS	0%	8.4%	
- non-Rx SpA			
Disease duration, mean (SD)	34.83 ± 13.71	22.84 ± 15.35	<0.0001*
Age at diagnosis, median (IQR)	33 ± 22	30 ± 16	0.138
NSAID (>25%)	22%	36.4%	0.003*
Biologic	24.4%	27.9%	0.641
BASDAI	4.005 ± 2.1	3.5 ± 2.13	0.156
BASFI	5.2 ± 2.56	3.5 ± 2.61	<0.0001*
ASDAS-CRP	2.57 ± 0.87	2.22 ± 0.92	0.04*
ASDAS-ESR	2.66 ± 0.9	2.23 ± 0.87	0.01*
CRP, median (IQR)	3.8 ± 6.65	3.0 ± 5.65	0.052
ESR, median (IQR)	15 ± 23.3	8 ± 13	0.008*

*p<0.05

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SAT0342 RISK FACTORS FOR ARTHROPATHY IN ULCERATIVE COLITIS PATIENTS AFTER TOTAL COLECTOMY; A RETROSPECTIVE, A SINGLE CENTER STUDY

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Background: Ulcerative colitis (UC) is associated with a variety of extra-intestinal manifestations (EIMs) that may have negative effects on performance status and quality of life. EIMs frequently affect musculoskeletal systems (peripheral and axial arthropathies), skin, hepatobiliary tract and eyes^{1,2}. Previous studies showed that peripheral and axial arthropathies were seen 4-23% patients with UC and they tend to have peripheral rather than axial arthropathies³. UC is generally thought to become in remission when patients undergo total colectomy. However, in clinical practice, patients often suffered from arthropathy which is thought as EIMs even after total colectomy. The distribution and risk factors for the occurrence of peripheral and axial arthropathies among UC patients after total colectomy have not been investigated yet.

Objectives: In this study, we aimed to clarify frequency and distribution of arthropathy and to investigate risk factors for developing arthropathy among UC patients after colectomy.

Methods: In this retrospective, single center, observational study, we investigated the backgrounds and risk factors for arthropathy using patients underwent total colectomy from January 2007 to February 2016 in Mie University. As backgrounds, age, sex, presence and distribution of arthropathy, other EIMs, and duration after colectomy, clinical activity (mild/moderate/severe), Matts classification (grade 1+2 vs 3+4), presence of massive hemorrhage and toxic megacolon, previous therapies for UC were collected from electronic medical records. Arthropathy was defined as joint pain or swelling without definite cause which was improved by using glucocorticoid. Background factors were described as median (IQR) for continuous variables or as percentage (%) for categorical variables and difference was analyzed by Wilcoxon for continuous variables and by chi-square for categorical variables. Factors with p-value < 0.1 in univariate analyses were included in multivariate logistic regression analysis for risk of developing arthropathy.

Results: We enrolled 219 patients (female; 40.2% and median age at operation; 38.0 [27.0, 53.0] years). Among them, 40 (18.3%) patients had arthropathy, peripheral type in 23 (57.5%), axial type in 3 (7.5%), mixed type in 14 (35.0%). Duration from operation to onset of arthropathy was 0.7 [0.4, 1.2] years. The risk factors for developing arthropathy by univariate analyses were Matts classification (grade 3+4 vs 1+2) (p < 0.05), follow up periods (p < 0.001), presence of other EIMs (p < 0.001), ileal pouchitis (p < 0.01), but previous treatment of biologics was not significant (p = 0.84). Table 1 showed the risk factors for developing arthropathy by multivariate logistic regression analysis using age, sex,

Matts classification, follow up period, presence of other EIMs and ileal pouchitis. Follow up period [OR 1.17 (95% CI 1.03-1.33, $p < 0.05$)], Matts classification [OR 2.61 (95% CI 1.19-5.74, $p < 0.05$)] and ileal pouchitis [OR 2.65 (95% CI 1.16-6.07, $p < 0.05$)] were significantly associated with an increased risk of developing arthropathy of UC patients after colectomy.

Table 1. The risk factors for developing arthropathy in patients with ulcerative colitis after underwent colectomy by multi variate logistic regression analysis.

	Odd ratio	95% CI	p value
Age at operation, years	1.02	0.99, 1.04	NS
Sex (female vs male)	1.81	0.84, 3.91	NS
Follow-up period, years	1.17	1.03, 1.33	<0.05
Matts Classification (grade 3+4 vs 1+2)	2.61	1.19, 5.74	<0.05
Ileal pouchitis	2.65	1.16, 6.07	<0.05
Extraintestinal manifestations	2.74	0.85, 8.87	NS

Conclusion: About one fifth patients with UC who underwent colectomy developed arthropathy presenting predominantly peripheral type. Long follow up period, High disease activity by endoscopic classification, and ileal pouchitis were risk factors of developing arthropathy in UC patients after total colectomy. The frequency and risk factors for developing arthropathy even after colectomy was demonstrated in this study for the first time.

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SAT0343

BURDEN OF DISEASE AT TREATMENT INITIATION AMONG BIOLOGIC-NAÏVE PATIENTS WITH OLIGOARTICULAR VERSUS POLYARTICULAR PSORIATIC ARTHRITIS IN THE CORONA PSORIATIC ARTHRITIS/SPONDYLOARTHRITIS REGISTRY

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Background: Oligoarticular PsA accounts for ≈50% of PsA worldwide, but only a paucity of data describes disease burden among patients with this subtype. The Corona PsA/SpA Registry, a prospective, US-based, observational cohort study, collects real-world data on characteristics and treatment of PsA patients, including those with oligoarthritis.

Objectives: To characterize demographics, clinical characteristics and patient-reported outcomes (PROs) at treatment initiation in biologic-naïve patients with oligoarticular (≤4 swollen and ≤4 tender joints) vs. polyarticular (>4 swollen or >4 tender joints) PsA.

Methods: Biologic-naïve patients ≥18 years of age diagnosed with PsA and enrolled in the registry who initiated apremilast, biologics and/or csDMARDs for PsA from March 2013–December 2018 were included. Data on patient demographics, disease activity, treatment history, comorbidities and PROs were analyzed at treatment initiation; comparisons between oligoarticular and polyarticular PsA patients were performed using *t*-tests or Wilcoxon rank-sum tests for continuous variables and chi-square tests or Fisher's exact tests for categorical variables, as appropriate.

Results: 330 biologic-naïve PsA patients initiating apremilast, biologics and/or csDMARDs were included (oligoarthritis: n=149; polyarthritis: n=181). Demographics and clinical characteristics were mostly similar for patients with oligoarthritis and polyarthritis, including mean age (51.6 vs. 54.3 years; $P=0.068$), proportion of females (51.0% vs. 59.7%; $P=0.117$), mean disease duration (3.0 vs. 3.1 years; $P=0.789$) and prior use of

csDMARDs (13.4% vs. 21.0%; $P=0.072$). History of comorbidities was similar between the 2 groups, but the proportion of patients with fibromyalgia was higher in the polyarthritis group (2.0% vs. 8.8%; $P=0.008$; Table 1). Patients with oligoarthritis had lower disease activity at treatment initiation vs. those with polyarthritis based on SJC (0-66) and TJC (0-68), nail psoriasis VAS score, cDAPSA score, presence of enthesitis, SPARCC enthesitis score, presence of dactylitis and dactylitis count. More patients with oligoarthritis were classified with minimal disease activity vs. patients with polyarthritis (Table 2). Mean Pain VAS (42.6 vs. 59.8), Fatigue VAS (41.9 vs. 55.3), Patient's Global Assessment of Disease Activity VAS (38.6 vs. 47.7) and HAQ-DI (0.7 vs. 1.0) scores were significantly lower and the proportion of patients with HAQ-DI score <0.5 was significantly greater for patients with oligoarthritis vs. polyarthritis (39.7% vs. 20.1%) (all $P \leq 0.001$). Presence of inflammatory back pain (8.7% vs. 10.5%; $P=0.588$) and mean psoriasis-involved body surface area (8.0% vs. 6.8%; $P=0.276$) were similar in the 2 groups.

Conclusion: This Corona PsA/SpA Registry analysis showed similar overall disease burden and comorbidity burden in biologic-naïve patients with oligoarthritis and polyarthritis. However, patients with oligoarthritis vs. polyarthritis had lower scores on disease activity and PRO measures at treatment initiation.

Table 1. History of Comorbid Conditions Among Biologic-Naïve Patients With Oligoarticular vs. Polyarticular PsA^{a,b}

History of Comorbidity, n (%)	Oligoarthritis n=149	Polyarthritis n=181	P Value
Cancer (any except NMSC)	15 (10.1)	19 (10.5)	0.898
Cardiovascular disease	17 (11.4)	23 (12.7)	0.719
Depression	20 (13.4)	36 (19.9)	0.119
Diabetes mellitus	20 (13.4)	33 (18.2)	0.236
Fibromyalgia	3 (2.0)	16 (8.8)	0.008
Hyperlipidemia	26 (17.4)	38 (21.0)	0.418
Hypertension	48 (32.2)	74 (40.9)	0.104
Metabolic syndrome	19 (12.8)	33 (18.2)	0.174
Nail psoriasis	65 (43.6)	97 (53.6)	0.071
Psoriasis	121 (81.2)	150 (82.9)	0.694

^aOligoarticular PsA (≤4 swollen and ≤4 tender joints) vs. polyarticular PsA (>4 swollen or >4 tender joints). ^bIncludes patients initiated on apremilast, biologics and/or csDMARDs. NMSC=non-melanoma skin cancer.

Table 2. Disease Characteristics of Biologic-Naïve Patients With Oligoarticular vs. Polyarticular PsA^{a,b}

Disease Characteristic	Oligoarthritis n=149	Polyarthritis n=181	P Value
Swollen joint count (0-66), mean (SD)	1.3 (1.5)	6.2 (5.3)	<0.001
Tender joint count (0-68), mean (SD)	1.6 (1.5)	13.9 (12.7)	<0.001
Nail psoriasis VAS, mean (SD)	11.4 (23.6)	15.7 (24.6)	0.037
cDAPSA score, mean (SD)	10.9 (5.6)	31.1 (15.8)	<0.001
High (>27) cDAPSA, n (%)	0 (0.0)	91 (52.0)	<0.001
Presence of enthesitis, n (%)	37 (24.8)	84 (46.4)	<0.001
SPARCC enthesitis score, mean (SD)	2.1 (1.3)	4.4 (3.4)	<0.001
Presence of dactylitis, n (%)	25 (16.8)	54 (29.8)	0.006
Dactylitis count, mean (SD)	1.9 (1.6)	2.4 (1.7)	0.060
Minimal disease activity, n (%)	40 (29.6)	6 (3.6)	<0.001

^aOligoarticular PsA (≤4 swollen and ≤4 tender joints) vs. polyarticular PsA (>4 swollen or >4 tender joints). ^bIncludes patients initiated on apremilast, biologics and/or csDMARDs. SPARCC=Spondyloarthritis Research Consortium of Canada.

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