Thus patients with smaller deposits were more likely to completely resolve the deposits.
Conclusion: We show that both life-style intervention and conventional urate lowering drug therapy reduce the volume of monosodium urate deposits. The size of MSU deposits, but not serum urate level, was the main factor that influenced complete resolution of deposits. This finding reemphasizes that the burden of deposits essentially defines the likelihood and time for complete resolution of gout.

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SAT0414 CLINICAL PRESENTATION OF PAGET DISEASE OF BONE: IS IT CHANGING? A RETROSPECTIVE ANALYSIS ON 368 PATIENTS

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Background: In the last few years, it has been reported a secular change of Paget disease of bone (PDB), expressed as a reduction of prevalence[1] and severity, assessed by disease extent[2].
Objectives: To retrospectively evaluate the baseline clinical and demographic characteristics of a contemporary cohort of patients affected by PDB, compared with a cohort of a previous decade[3].
Methods: Data were retrospectively extracted from a monocentric registry, which included PDB patients at their first evaluation in a tertiary rheumatology Center between January 2000 and September 2018. Descriptive data of baseline characteristics included demographics, presenting manifestation and diagnostic procedures (diagnosed by chance or by investigations requested for specific clinical manifestations), extent of PDB, and biochemical data. Patients were divided into two groups according to the year of first evaluation: group 1 before July 2007, group 2 after July 2007. Comparisons between the two groups were performed by T test and chi-square test; logistic regression was used to analyze the association between disease extent and other collected variables.
Results: The overall population included 368 patients (males (M) 57.6%, mean age at diagnosis [± standard deviation, SD] 62.0±12.4 yrs). Diagnosis was made by chance in 43.8% cases, 54.3% patients had symptoms at disease onset; 49.5% was monostotic, mean serum alkaline phosphatase at presentation (sALP) was 198.5±167.5 UI/L.
Group 1 included 217 patients (M 56.2%, mean age at diagnosis 61.0 ±11.6 yrs, 6.5% family history of PDB; 45.6% diagnosed by chance, 51.2% had symptoms at disease onset, mean sALP 218.9±11,7, 43.3% monostotic). Group 2 included 151 subjects (M 59.6%, mean age at diagnosis 64.3±11.1 yrs, 7.3% family history of PDB; 41.1% diagnosed by chance, 62.9% had symptoms at disease onset, mean sALP 162.7 ±14,2,58.3% monostotic).
Poliostotic disease was significantly higher in Group 1 vs Group 2 (p=0.007), and the odd to have a poliostotic disease was higher in Group 1 [OR 1.82 (IC 1.2-2.8), p<0,005]. sALP was significantly higher in Group 1 vs Group 2 (218,9±11,7 vs 162,7±14,2; p=0,003). No differences were found in sex, age at diagnosis, presence of family history of PDB between patients diagnosed incidentally or by symptoms.
Conclusion: Our data confirm the reduction of clinical severity, assessed by the proportion of skeleton involved, and the decrease of biochemical markers over time. The reduction of the disease extent is consistent with a serological biomarker of the disease, such as mean sALP levels.

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SAT0415 HIGH BODY FAT OF TRUNK IS POSITIVELY CORRELATED WITH SERUM URIC ACID IN MALE GOUT PATIENTS

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Background: Obesity is an important risk factor of gout which is defined by body mass index (BMI). However, BMI has been challenged for the limitation of failure to differentiate comprising tissues of the body. More accurate body composition (BC) has been frequently recommended to assess metabolic status.
Objectives: To investigate the characteristics of BC in gout patients and its clinical significance.
Methods: Consecutive gout patients who fulfilled the 2016 ACR/EULAR classification criteria were recruited between June 2017 and December 2018. BC was assessed by bioelectric impedance analysis including body fat percentage (BF%), the mass and distribution of muscle and fat in trunk and appendicular extremities. Demographic information, clinical characteristics and comorbidities were collected. Overfat was defined by BF% $\geq$25% for male and $\geq$35% for female.
Results: Among 362 recruited gout patients, 96.1% were male and the median age was 38 (30, 50) years, mean serum uric acid (sUA) was 9.2±2.2mg/dl, 18.0% presented tophi. The mean BF% was 25.8±6.4% with 53.6% overfat. Male gout patients with overfat (53.7%) showed more affecting joints, higher sUA and higher prevalence of comorbidities than those without overfat (P<0.05, Figure 1). Their BF%, trunk BF% and limb BF% were positively correlated with count of affecting joints, sUA, hypertension, metabolic syndrome and fatty liver in Spearman correlation analysis, respectively (r=0.133~0.424, all P<0.05). The male patients with overfat also presented higher BMI and waist circumstance (WC), higher trunk/limb BF% ratio (P<0.05, Figure 1). Their BF%, trunk BF% and limb BF% were also positively correlated with BMI and WC, respectively (r=0.604~0.755, all P<0.05). After adjustment for age, duration, family history, eGFR, hypertension, diabetes mellitus, dyslipidemia, metabolic syndrome, fatty liver, coronary heart diseases, urolithiasis, BMI and WC, multivariable linear regression showed that BF% (β=0.072, 95%*CI*