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Assessment of Body Composition in Lean Mass and Fat Mass in Spondyloarthritides

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Background: Mohamed Montacer Kchir is a gold standard for the study of body composition. It allows to separate lean mass (LM) and fat mass (FM), and is the gold standard for the study of body composition. The mean bone mineral density (BMD) at the lumbar spine was 1.033 g/cm² (with a mean T score of -1.5 DS and Z score = 1.3 DS) while it was 0.956 g/cm² at upper end of the femur level (with a mean T score of -0.8 and a mean Z score of -1.2 DS). In controls, the mean BMD was 1.055 g/cm² and 1.013 g/cm² at the lumbar spine and upper end of the femur respectively (with a mean T score of -1.4 DS and -0.5 SD and a mean Z score of -1.4 and -0.3 respectively at the lumbar and superior femoral sites). In the SpA group, the mean value of whole body FM was 31.6%, whereas this average was around 36% in controls. FM was distributed as follows: 39.2% at the android level, 59.7% at the gynoid level. The SpA group and their healthy controls were comparable in terms of FM and LM measurements and their distributions. We found a significant correlation between the rate of CRP and the measurements of FM at the android level (r = -0.358, p = 0.023) (and conversely the LM at the android level). However, we found no association between disease activity (BASDAI) and body composition.

Conclusion: Changes in body composition (MM/MG) related to chronic inflammatory status may occur during chronic inflammatory diseases. However, few studies in the world have focused on changes in the body composition and their distribution in SpA.

Disclosure of Interests: None declared


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Establishment of BasdaI Cut-offs for the Disease Activity States Based on Asdas Cut-offs in Taiwanese Ankylosing Spondylitis Patients

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Background: The Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) has been widely utilized to evaluate disease activity in patients with ankylosing spondylitis (AS). However, the cut-off of BASDAI used to indicate high disease activity (i.e., >4) was determined arbitrarily and was suggested as a criterion to initiate biological therapy for AS patients. The Ankylosing Spondylitis Disease Activity Score (ASDAS) has been developed as a new composite index to assess AS disease activity. The cut-off values for disease activity states has been defined and validated. ASDAS > 2.1 was selected as a criterion of starting biological therapy. However, the BASDAI cut-off values corresponding to the ASDAS cut-off values for disease activity states were unknown.

Objectives: The purpose of this study was to estimate the corresponding BASDAI and ASDAS cut-off in a Taiwanese AS cohort.

Methods: Since November 2016, we assessed the Ankylosing Spondylitis Disease Activity Score (ASDAS) and the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) regularly and recorded demographic data, comorbidity, family history, medication use for AS patients in Taichung Veterans General hospital (TCVGH) using an electronic patient reported data system linked to an electronic medical record system. We identified 489 AS patients with complete baseline demographic and assessment data from the TCVGH electronic data system during 2016/11–2018/10. We used receiver operating characteristic (ROC) curves with Youden’s J statistic to determine the cut-off values of BASDAI that correspond to ASDAS disease activity cut-offs (i.e., 1.3, 2.1 and 3.5).

Results: We included a total of 489 AS patients [114 (23.3%) females, mean age 44.1 years (S.D. 13.9), mean symptom duration 18.0 years (S. D. 11.9), 152 (31.1%) current biologic users]. Mean BASDAI, ASDAS-ESR and ASDAS-CRP scores were 2.1 (S.D. 1.5), 1.6 (S.D. 0.8) and 1.5 (S.D. 0.9) respectively. Mean levels of CRP and ESR were 0.6 (S.D. 1.5) mg/dl and 12.2 (S.D. 14.0) mm/hr respectively. Based on ASDAS-CRP, the numbers (%) of AS patients with inactive disease (<1.3), low disease activity (1.3-2.1), high disease activity (2.1-3.5) and very high disease activity (≥3.5) were 210 (42.9%), 171 (35.0%), 88 (18.0%) and 20 (4.1%) respectively. Based on ASDAS-ESR, the numbers (%) of AS patients with inactive disease, low disease activity, high disease activity and very high disease activity were 202 (41.3), 174 (35.6), 96 (19.6) and 17 (3.5).