Irish or Other) and 30 non-Caucasian patients. 49 patients (36 Caucasian and 13 non-Caucasian) had confirmed radiographic axial SpA. 17 patients (10 Caucasian and 7 non-Caucasian) had confirmed non-radiographic axial SpA.

Based on available data for 57 patients, the median time of symptom onset to GP presentation was 48 months. Based on available data for 49 patients, the median time of symptom onset to diagnosis was 53 months. The mean time of symptom onset to GP presentation was 93 months in Caucasians compared to 66 months in non-Caucasians. The mean time of symptom onset to diagnosis was 91 months in Caucasians compared to 70 months in non-Caucasians. 12 patients presented within 1 year of symptom onset.

Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) data were available for 7 out of 12 patients who presented within 1 year of symptom onset and 25 out of 45 patients who presented after 1 year. Following NSAIDs or biologics, there was a larger decrease in the first measured BASDAI for those who presented within 1 year of symptom onset (Mean BASDAI decrease: 2.77 compared to 2.06).

For those presenting within 1 year of symptom onset, BASDAI data were available for 5 out of 7 Caucasian and 2 out of 5 non-Caucasian patients. The mean BASDAI decrease was 5.65 in non-Caucasian patients compared to 1.62 in Caucasian patients.

For those presenting after 1 year of symptom onset, BASDAI data were available for 15 out of 26 Caucasian and 10 out of 19 non-Caucasian patients. Mean BASDAI decrease was 2.26 in non-Caucasian and 1.93 in Caucasian patients.

BASDAI data were available for 43 out of 70 Caucasian patients and 18 out of 30 non-Caucasian patients, regardless of time of presentation. The mean decrease in first measured BASDAI was smaller in Caucasian patients compared to non-Caucasian patients (Mean BASDAI decrease: 2.49 compared to 2.66).

Conclusion: There is a shorter mean time of symptom onset to GP presentation and diagnosis in non-Caucasian patients compared to Caucasians. There is a higher response to treatment in patients who present within one year of symptom onset. This may support the hypothesis that early diagnosis leads to better outcomes.

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AB0730 RECLASSIFICATION INTO VERY HIGH CARDIOVASCULAR RISK AFTER CAROTID ULTRASOUND IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Axial spondyloarthritis (a-SpA) are associated with an increase in cardiovascular (CV) morbidity and mortality. Subclinical atherosclerosis, in the form of carotid plaques, is more frequent in this patients than in healthy controls. How the presence of carotid plaque affects the reclassification of CV risk in a-SpA has not been study before. Besides, it is not known if this reclassification can be explained by characteristics related to the disease.

Objectives: To analyze whether the reclassification of CV risk after performing carotid ultrasound is more frequent in this patients compared to controls and whether this reclassification can be explained by characteristics related to the disease such as activity, functional damage or metrolgy scores.

Methods: Study of 343 a-SpA patients according to ASAS criteria and 177 controls with no previous history of CV events, diabetes or chronic kidney disease. The clinical characteristics and risk profile were analyzed in patients and controls by SCORE. The presence of plaques and intima-media thickness (cIMT) was determined by carotid ultrasound. The differences in the presence of reclassification between patients and controls and the factors associated with this in patients with a-SpA, were analyzed by multivariate regression analysis.

Results: Patients with a-SpA compared to controls disclosed a higher presence of hypertension (p=0.000), dyslipidemia (p=0.000) and smoking (p=0.000). Consequently, patients also showed a significantly higher SCORE than controls (0.6 IQR [0.1-2.0] vs. 0.1 [0.0-0.4], p=0.000). The presence of carotid plaque (36% vs. 25%, p=0.010) and cIMT (0.641 ± 0.121 vs. 0.602 ± 0.115 mm, p=0.001) were higher in patients compared to controls. Moreover, the possibility of being reclassified into very high-risk category after ultrasound was superior in patients (34% vs 25%, p=0.037). The possibility of being reclassified was associated, both in patients and controls, with an older age, male sex, abdominal circumference, hypertension and dyslipidemia. Contrary, body mass index and

serum levels of cholesterol, LDL cholesterol and atherogenic index only showed association with reclassification in controls. The effect of each factor associated with reclassification in patients and controls was compared by the addition of interaction factors in the regression model. In this sense, age (beta coef 2.74 [IC95% 1.34-5.62] in controls vs. beta coef 0.63 (95% CI 0.40-0.99) in patients, interaction $p=0.001$) and serum LDL cholesterol levels (beta coef 1.03 [IC95% 1.02-1.04] vs. beta coef 1.00 [0.99-1.01], interaction $p=0.002$), cholesterol and atherogenic index, showed a greater effect in controls than in patients. The reclassification in patients with a-SpA was associated with a higher ASDAS-PCR (2.2 ± 1.0 VS. 2.5 ± 1.0 , $p=0.041$), BASFI (3 [1-5] vs. 4 [2-7], $p=0.000$) and BASMI scores (2 [1-4] vs. 4 [2-5], $p=0.000$). However, these differences were lost when they were analyzed adjusting for CV risk factors.

Conclusion: Patients with a-SpA are more likely to be reclassified into very high-risk after carotid ultrasound compared to controls. Traditional CV risk factors have less effect on this reclassification in patients than in controls. The activity, functionality and metrology scores of the a-SpA have a univariate positive relationship with this reclassification.

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AB0731 RATE OF SACROILIITIS RADIOGRAPHIC PROGRESSION IN MALE AND FEMALE PATIENTS WITH EARLY AXIAL SPONDYLOARTHRITIS

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Background: According recent studies radiographic progression (mSASSS) of male patients (pts) with ankylosing spondylitis (AS) higher than in female pts [1, 2].

Objectives: to compare radiographic progression of early axial spondyloarthritis (axSpA) in male and female pts over 2 years (y) of follow-up (FUP).

Methods: The research included 68 pts with early axSpA (ASAS criteria, 2009) from Moscow CORSAR cohort with disease duration <5 and age onset <45 years. The mSASSS index is not suitable for assessing radiographic progression at an early stage of axSpA, because at that stage of the disease, the cervical and lumbar spine have practically no damage. Sacroiliac joints (SIJ) radiographs and CRP performed at baseline and after 2 y FUP. Radiographic SIJ stages scored according to the modified New York criteria grading system. To assess the progression in SIJ, total stage of sacroiliitis (TSS) calculated, by determining sum score stages of sacroiliitis (SI) in the left and right SIJ (from 0 to 8 points). The following formula used to calculate the rate of SI radiographic progression:

$$\text{Rate of SI radiographic progression} = \frac{(TSS^2 - TSS^1) \times 12}{FUP}$$

*TSS¹ - initial total score stages of SI, TSS² - FUP total score stages of SI

Pts mean age was 28,5 (5,8) y, average disease duration - 24,1 (15,4) mo, 63 (92,6%) pts were HLA-B27 positive.

Results: Initially, among men there were more pts with AS than among women and they had a higher TSS and higher CRP level (table 1). Rate of SI radiographic progression in male and female pts with axSpA at baseline did not differ.

Abstract AB0731 Table 1.. Outcome parameters at baseline.

	Men (n=33)	Women (n=35)	p
Ankylosing spondylitis, n,%	25 (75,5%)	15 (42,8%)	0,007
Non-radiographic axSpA, n,%	8 (24,5%)	20 (57,2%)	0,005
Total stage of sacroiliitis, mediane [IQR]	4,0 [4,0; 5,0]	3,0 [2,0; 4,0]	0,021
Rate of SI radiographic progression, mediane [IQR]	2,3 [1,3; 4,0]	2,0 [1,0; 4,0]	0,364
CRP, mediane [IQR]	12,8 [1,7; 31,8]	4,3 [0,9; 9,8]	0,041

After 2 y FUP, pts with AS still prevailed among men (table 2). TSS increased in both groups: in female pts from 3[2,0; 4,0] to 4 [3,0; 4,0] ($p<0,05$), in male pts from 4,0 [4,0; 5,0] to 4 [4,0; 6,0] ($p<0,05$). But, however, in female pts TSS remained less than in male pts over 2 y FUP (table 2). CRP level still was higher in male pts ($p<0,05$). Progression from non-radiographic axSpA to AS between male and female pts didn't differ - 5 (15,5%) vs 6 (17,2%), $p>0,05$ respectively, after 2 y FUP. In both groups rate of SI radiographic progression after 2 y decreased ($p<0,05$) and did not differ between them.

Abstract AB0731 Table 2.. Outcome parameters after 2 y of FUP.

	Men (n=33)	Women (n=35)	p
Ankylosing spondylitis, n,%	30 (90,9%)	21 (60,0%)	0,003
Non-radiographic axSpA, n,%	3 (9,1%)	14 (40,0%)	0,003
Total stage of sacroiliitis, mediane [IQR]	4,0 [4,0; 6,0]	4,0 [3,0; 4,0]	0,006
Rate of SI radiographic progression, mediane [IQR]	0 [0; 1,0]	0 [0; 0,5]	0,98
CRP, Me, [25%; 75%]	5,0 [1,0; 12,7]	1,2 [0,6; 4,0]	0,005

Conclusion: 1. Rate of SI radiographic progression in male and female pts with axSpA in the first 2 y from the onset of disease is higher than in further. 2. Rate of SI radiographic progression between male and female pts with axSpA is not differ. 3. Male pts with AS more than female pts in CORSAR cohort. It can be explained that male pts had higher CRP level than female pts.

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AB0732 THE ASSOCIATION BETWEEN PERIODONTAL DISEASE AND RISK OF ANKYLOSING SPONDYLITIS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: The association between periodontal disease and rheumatoid arthritis is well-recognized [1]. *Porphyromonas gingivalis* is probably the link between the two conditions. On the other hand, the data on the