study period and of these, random selection of 10% i.e. 250 subjects were considered for the study. Baseline demographics, medical comorbidities, laboratory findings, acute care visits, medication history and family history were recorded. Patients who were followed by rheumatologist or primary care physician (PCP) were extracted from electronic health record.

We used Stat view Version 5.01 (SAS Institute Inc. Cary, NC) for analysis. We described data with frequency terms, continuous data by mean ± standard deviation, and categorical data by percent. Univariate analysis identified predictors of interest that were later incorporated in the best fit model with logistic regression. A p value of < 0.05 was considered statistically significant.

**Results:** The mean age of subjects was 61 ±11 years, mean BMI was 32 ± 7 kg/m2, 98% were males and 80% were African Americans. 26% of subjects had history of alcohol use, 89% had hypertension and 90% had chronic kidney disease (CKD stage ≥2), 86% of the subjects were followed by primary care physician (PCP), and 5% of them were followed by rheumatology and rest of the 9% were non- compliant. 30% of subjects were receiving urate-lowering therapy and 23% of patients were on gout prophylactic therapy. 21% of patients had multiple (> 2) visits to the ED. The mean uric acid level was 8.5 ± 2.1 mg/dl for subjects with single visit compared to 9.04 ± 2.1 mg/dl for multiple visits to the ED (P = 0.09).

In the univariate analysis, CKD (stage ≥ 2) and higher uric acid level were associated with increased ED visits (P = 0.09) and not being on urate lowering therapy was also associated with increased frequency of ED visits (P = 0.02). On logistic regression analysis, irrespective of the type of physician follow up (PCP vs rheumatologists), being on urate-lowering therapy was associated with reduced frequency of ED visits (P=0.02).

**Conclusion:** Urate-lowering therapy (ULT) was associated with reduced ED visit irrespective of follow up care provided by PCP or rheumatologist. Given that only one third of our patients were on ULT, improving ULT dispensing by the physician and patient compliance with ULT can decrease health care utilization.

**REFERENCE**


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**AB0881**

**DESCRIPTIVE ANALYSIS OF PATIENTS WITH OSTEONECROSIS IMPERFECTA IN A TERTIARY HOSPITAL IN MADRID**

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**Background:** Osteogenesis imperfecta (OI) is an inherited connective tissue disorder with an incidence of 1 per 20,000 births. It is also called “brittle bone disease” and is most commonly caused by mutations in genes encoding type I collagen or proteins involved in its posttranslational modification. Most patients have an autosomal dominant mutation in COL1A1 or COL1A2. The severity of the clinical presentation depends upon the effect of the mutation that occurs, having many different pheno-
typic presentations. In the most severe forms, patients suffer multiple fractures with minimal or no trauma whereas mild forms may only manifest with premature osteoporosis. Attending to the clinical presentation, radiographic findings and the mutational analysis, 11 different types have been described. Types I and III being the most prevalent. In our patients, this evaluation was prospective after the begin of the study. The most frequently used are bisphosphonates which try to prevent bone fragility and reduce the number of fractures but none have been approved specifically for use in either children or adults with OI.

**Objectives:** The aim of the study is to analyse the clinical characteristics of osteogenesis imperfecta (OI) patients followed in our hospital and to evaluate the different treatments used in their management.

**Methods:** A retrospective study was conducted. All patients diagnosed with OI and seen in the different departments of our hospital were included and analyzed. A database was created, including both clinical and epidemiological data and a descriptive analysis was carried out.

**Results:** 25 patients with OI are currently being followed up in our hospital and were included. Although most patients were being followed in both the Rheumatology (9) and Orthopedic units (9), 4 were being followed by pediatrics, 1 by endocrinology, 1 by internal medicine and 1 by geriatrics. 72% were female (18) with a mean age at diagnosis of 17 years (range: 1 month to 67 years). All of them had had previous fractures before the diagnosis. The number of fractures during their follow-up varied according to the different types of OI, with an average of 6 fractures (range 3-24) per patient and an average of at least 4.16 orthopedic surgeries each. 12/25 patients were diagnosed in the first ten years of life, being the ones that accumulated the highest number of fractures (96 vs. 54). Only 3 patients had family background of OI, all of them being type I. Although only 8/25 patients had undergone genetic study, all 3 cases of type III, which is the most severe, debuted in the first decade of life. Phenotypically 14/25 (56%) had short stature and 18/25 (72%) had blue sclerae, being these less frequent in those patients with debut after 20 years of age, of which 57% (4/7) had normal sclerotics. Only 4 patients suffered from dentinogenesis imperfecta (16%) and 3 from oto-
sclerosis and had hearing problems (12%). Regarding the treatment received, 60% of the patients (15/25) were on current treatment with oral calcium and 64% (16/25) with oral vitamin D supplements. On the other hand only 60% of the patients received bisphosphonates (4 were being treated with risedronate, 7 with pamidronate, and 4 had received both zoledronic and pamidronate during their lives).

**Conclusion:** Although a rare disease, OI has an important morbimortality in most patients. Severe cases suffer multiple fractures and undergo sev-
eral orthopedic surgeries during their lifes. Given the high cost of genetic analysis, this is reserved for the most severe cases which tend to debut at younger ages and are mostly type III. Treatment for this condition is not standardized and is generally reserved for type III OI patients, which is one of the most severe types. Bisphosphonates, calcium and vitamin D are usually used in order to try to prevent new fragility fractures but in most cases fracture rates remain high despite treatment.

**Disclosure of Interests:** None declared

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