AB1241

MOST PREVALENT COMORBIDITIES IN PRIMARY SJÖGREN'S SYNDROME IN A HISPANIC POPULATION

Nicolás Alfaro¹, Janett Carmen Riegatorres², Gabriela Hernandez-Molina³, Rosa-Elda Barbosa-Cobos⁴, Ana Cecilia Arana Guajardo², Mario Alberto Garza Elizondo², Dionicio Ángel Galarza-Delgado², Cassandra Michele Skinner Taylor², Amaya Llorente-Chavez³, Cesar Vidal Solis². ¹Hospital Universitario "Dr. José Eleuterio González", Servicio de Reumatología e Inmunología Clínica, Monterrey, Nuevo León, Mexico; ²Hospital Universitario "Dr. José Eleuterio González", Servicio de Reumatología e Inmunología Clínica, Monterrey, Nuevo León, Mexico; ³Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Department of Immunology and Rheumatology, Ciudad de México, Mexico; ⁴Hospital Juárez de Mexico, Department of Rheumatology, Ciudad de México, Mexico

Background: Comorbidities are an important issue to consider in patients with rheumatic diseases (RD), as well as the clinical assessment of the autoimmune disease. Looking for concomitant diseases is a necessary step for a global approach of the rheumatic patient, knowingly that some diseases are more frequent in patients with RD than in the general population and could influence the course of RD and achievement of treatment goals¹. Despite this, there is a need of new evidence about primary Sjögren's Syndrome (pSS) comorbidities and their association with clinical outcomes.

Comorbidities in patients with primary Sjögren's Syndrome

Figure 1

Objectives: To determine the prevalence of comorbidities in patients with pSS in Mexican population.

Methods: This was a national, multicenter, cross-sectional, and observational study. We included 393 patients with pSS, diagnosed according to the American-European Consensus Group (AECG) criteria 2002 or ACR/EULAR 2012 criteria. Comorbidities, serological profile of autoantibodies, Schirmer's test, sialometry and histopathological assessment from minor salivary gland biopsies reported in the medical records were evaluated by a rheumatologist. The comparisons between the study groups were carried out using the two-tailed Student's t test, χ^2 test, and unidirectional. A value of $p < 0.05$ was considered statistically significant.

Results: At least one comorbidity were reported in 310 (78.9%) patients, 2 to 4 comorbidities were reported in 183 (46.6%), and only 18 (4.6%) had a least 5 comorbidities. Thyroid disease was the most frequent comorbidity, observed in 91 (23.2%) subjects, being hypothyroidism the main cause. Smoking (21.9%) and hypertension (19.6%) were in second and third place. Psychiatric disease was present in 62 (15.8%) patients being depression and anxiety disorders the most frequent, appearing in 49 (79%) and 12 (19.35%) patients respectively. Regarding malignancy, we documented 10 (2.5%) patients with lymphoma, and 4 (1%) patients with breast cancer. The rest of comorbidities are shown at Figure 1 and Table 1. There was no significant difference for each variable measured between the groups except for the mean age ($p = 0.001$).

Table 1. Demographic and clinical variables. $n=393$:

Variable	Comorbidities $n=310$	No comorbidities $n=83$	P
Age years, mean(SD)	58.52 (13.12)	48.57 (12.52)	0.001**
Female gender, n (%)	297 (95.8)	80 (96.4)	0.812
(+) Anti-Ro/SSA, n (%)	194 (62.6)	59 (71.1)	0.139

(+) Anti-La/SSB, n (%)	139 (44.8)	38 (45.8)	0.867
(+) Schirmer test, n (%)	210 (67.7)	50 (60.2)	0.102
Abnormal sialometry, n (%)	180 (58.1)	47 (56.6)	0.946
(+) GSM biopsy, n (%)	228 (73.5)	66 (79.5)	0.140
Use of corticosteroids, n (%)	113 (36.5)	27 (32.5)	0.430

GSM; Minor salivary gland. P; asymptotic significance, ** statistical significance

Conclusion: The systematic evaluation of comorbidities in patients with pSS is essential for an integral management. Physicians should be aware that these conditions might directly impact quality of life, prognosis, treatment response and healthcare costs. We encourage further research for the identification of new approaches in benefit of the patients.

REFERENCES

- [1] Yurkovich, et al. (2014). Overall and Cause-Specific Mortality in Patients With Systemic Lupus Erythematosus: A Meta-Analysis of Observational Studies. *Arthritis Care & Research*, 66(4), 608–616. <https://doi.org/10.1002/acr.22173>.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.1608

AB1242

COLCHICINE USE DURING PREGNANCY: CASE REPORTS

Nesrin Caglayan Duman¹, Murat Karabacak², Medine Gulcebi Idriz Oglu¹, Nevsun Inanc², Zehra Nur Turgan Asik¹, Pamir Atagündüz², Songul Ozkula¹, Rezzan Gulhan¹, Zafer Goren¹, Filiz Onat¹, Haner Direskeneli², Atila Karaalp¹. ¹Marmara University, School of Medicine, Department of Pharmacology, Istanbul, Turkey; ²Marmara University, School of Medicine, Division of Rheumatology, Department of Internal Medicine, Istanbul, Turkey

Background: If used during pregnancy it is known that colchicine passes through the placenta to the fetus¹. Although it has been shown to increase the risk of congenital malformations in animal studies, there is no increase in undesirable results in humans². The guidelines indicate that the use of colchicine in pregnancy and lactation is appropriate^{3,4}. However, data from clinical studies and case reports for the use of colchicine during pregnancy are not sufficient.

Objectives: The aim of this study was to evaluate pregnant and/or nursing patients who were consulted to our teratology information center for colchicine use.

Methods: Colchicine treated patients during pregnancy was included in this study. Patients consulted to our information service between 2012-2018 were evaluated for risk assessment of colchicine. Information regarding pregnancy outcomes was recorded by telephone interviews with patients.

Results: Indications for colchicine use in 34 cases (33 patients; one of them had pregnancy twice) were familial Mediterranean fever ($n=21$), Behçet's disease ($n=9$), systemic lupus erythematosus ($n=1$), ankylosing spondylitis ($n=1$) and vasculitis ($n=1$). Of the cases, 22 used the drug in pregnancy and lactation, 12 used only in pregnancy period. Of the 34 pregnancies, three had elective termination of pregnancy (the reason in one case was cytomegalovirus infection, the other is unplanned-unwanted and the other was unknown) and three had spontaneous abortion. Twenty eight had given birth, 19 of them were term and 9 of them were pre-term. Delivery mode of 18 were caesarean and 10 of them were vaginal birth. A total of 30 live birth infant (two twins) exposed to colchicine due to their mother's treatment. Twenty three infant was healthy and the remaining 7 had different problems. Four of them cardiac [minor cardiac septal defect which not needs operation ($n=2$), pink tetralogy of fallot ($n=1$), heart valve stenosis ($n=1$)], nephrolithiasis, inguinal hernia and death (respiratory distress after birth) (table 1).

Conclusion: Currently, systematic review and meta-analysis driven data suggests that colchicine does not significantly increase the incidence of foetal malformations or miscarriage and colchicine for FMF should not be withheld on this basis during pregnancy. Although the causality between colchicine use and the above reported mostly cardiac and rare problems such as tetralogy of fallot is not proven, the contribution of colchicine cannot be ruled out totally and should be beard in mind in cases of colchicine use for indications other than FMF or Behçet's disease.