ADL was suspended. These results suggest a direct relationship between the time of exposure to ADL and concomitant use with DMARDs and corticosteroids at dose >2.5 mg, similar findings are also described in other studies.

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AB1250 SLE AND SEXUAL FUNCTION: ARE WE FORGETTING MEN?

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Background: Whereas SLE is uncommon in men, the disease is usually more severe and requires more aggressive immunosuppression in male patients. There are multiple studies regarding sexual aspects in women with SLE, but information about sexual function in male patients is quite scant.

Objectives: To determine the relationship between SLE and sexual function alterations in men, through the application of validated questionnaires.

Methods: We performed a longitudinal study in a third-level referral center in Mexico City. We included men aged ≥16 years who fulfilled ACR criteria for SLE and who were sexually active. All subjects answered the International Index of Erectile Function-15 (IIEF-15), the SF-36 and the HAQ in two visits. Other clinical, serological and demographic variables were measured. Oxidized LDL was quantified by ELISA.

Results: We included 108 male SLE patients. Mean age was 37.2±1.1 years and most patients (87%) were taking immunosuppressive therapy. Comorbidities were present in 58% of subjects, with dyslipidemia and hypertension being the most prevalent (34% and 28%, respectively). The prevalence of sexual dysfunction (SD) was 53%. In the basal visit, the only significant differences between the patients with SD and those without SD were a lower education degree ($p=0.007$) and persistent lymphopenia ($p=0.01$). There was a positive correlation between global IIEF-15 score and SF-36 score ($r=0.46$, $p=0.001$). The physical function domain had the highest correlation ($r=0.50$, $p=0.001$). Likewise, there was a weak negative correlation between IIEF-15 and HAQ score ($r=-0.25$, $p=0.012$). Also, the IIEF-15 had a weak correlation with the absolute lymphocyte count ($r=0.27$, $p=0.005$) and oxidized LDL ($r=0.31$, $p=0.04$). In the follow-up visit the only significant differences between the patients with SD when compared with subjects without SD was a low absolute lymphocyte count (1031 ± 89 vs 1458 ± 119 , $p=0.005$); the correlations mentioned in the baseline visit remained significant. Regarding erectile function, 44% of the subjects had some degree of dysfunction. The rest of the variables are shown in Table 1.

Abstract AB1250 Table 1. Demographic, clinical and laboratory features

Variable	Mean ± SEM
Demographic	
Age (years)	37.2 ± 1.1
Body mass index (kg/m ²)	26.5 ± 0.4
Less than 10 years of schooling (n,%)	21/108 (19.4)
Time since SLE diagnosis (years)	9.1 ± 0.6

Clinical Features	
Total score IIEF-15	58.7 ± 1.3
Erectile function	23.9 ± 0.6
Intercourse satisfaction	10.9 ± 0.3
Orgasmic function	8.1 ± 0.2
Sexual desire	7.5 ± 0.1
Overall satisfaction	8.1 ± 0.1
Total score SF-36	69.2 ± 1.3
Secondary antiphospholipid syndrome (n,%)	16/108 (14.8)
SLEDAI score (points)	4.2 ± 0.4
Others comorbidities (n,%)	63/108 (58.3)
Laboratory features	
Hemoglobin (mg/dl)	15.3 ± 0.2
Leukocytes (mm ³) (x10 ³)	5.9 ± 0.2
Absolute lymphocyte count (mm ³)	1362.6 ± 76.0
Serum creatinine (mg/dl)	1.4 ± 0.1
C3 levels	104.1 ± 3.2
C4 levels	19.7 ± 1.2
Anti-dsDNA antibodies	208.2 ± 70.4
Use of immunosuppressive treatment (n,%)	95/108 (87.9)
Prednisone (n,%)	58/108 (53.7)
Azathioprine (n,%)	31/108 (28.7)
Antimalarial (n,%)	73/108 (67.5)
Mycophenolate mofetil (n,%)	42/108 (38.8)
Cyclophosphamide exposure previous 6 months (n,%)	7/108 (6.4)
Anticoagulation (n,%)	18/108 (16.6)
Non-immunosuppressive treatment (n,%)	85/108 (78.7)

Conclusion: Sexual function is affected in men with lupus, regardless of comorbidities and treatment. Interestingly, lymphopenia is persistently associated with an impaired sexual function, which could be related to the role it plays in endothelial dysfunction and atherosclerosis. The patients' disease perception, which is influenced by their academic level and physical role in their daily activities, seems to affect their sexual performance and quality of life.

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AB1251 ASSOCIATION BETWEEN VITAMIN D DEFICIENCY AND A HIGHER RATE OF DISEASE ACTIVITY IN PATIENTS WITH SPONDYLOARTHRITIS

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Background: Spondyloarthritis is a group of chronic inflammatory diseases with involvement of the axial skeleton (mainly), and also of peripheral joints. Patients with spondyloarthritis have a significant prevalence of vitamin D levels below normal and that would correlate with the degree of activity of the disease.

Objectives: To determine the association between vitamin D deficiency and the degree of activity of the disease (inflammatory activity) in a cohort of patients with spondyloarthritis.

Methods: Observational, extensive and transversal study. We propose a retrospective review of the database of patients with spondyloarthritis who were treated in the outpatient clinics of the Rheumatology Service of the General University Hospital of Ciudad Real during September 2016 to September 2018. Patients with the data will be selected. necessary for the analysis of the variables under study. The variables evaluated will be described using measures of frequency and measures of central tendency/dispersion as appropriate. To assess the association between vitamin D deficit and activity index, the odds ratio (OR) will be calculated. All analyzes were performed with a confidence level of 95% using SPSS 21.0.

Results: The first advances of the results of the study are presented. 101 patients were analyzed, of which 58 were men and 43 women, with an average age of 46.33 years (+/- 13.05 DE). 15 (14.85%) were non-radiographic axial spondyloarthritis, 48 (47.52%) ankylosing spondylitis, 24 (23.76%) psoriatic arthropathy, 3 (2.97%) spondyloarthropathy associated with inflammatory bowel disease, and 11 (10.89%) were other types of spondyloarthritis. The average of the activity was a BASDAI of 4.355 (+/- 2.376 SD), 64 patients were in activity (BASDAI > 4) and 31 patients (30.69%) with an elevation of acute phase reactants. Vitamin D levels were 24.52 (+/- 9.21 SD). 77 patients (76.24%) presented figures

of vitamin D deficiency or insufficiency. When performing the association analysis, the vitamin D deficit/insufficiency presented an OR 12.46 (95% CI: 4.07-38.08), $p = <0.0001$ with the degree of activity measured with BASDAI. Regarding the comparative analysis of means between vitamin D deficiency/insufficiency and BASDAI it is +2,253 (95% CI: 1,241 to 3,266, $p <0.0001$).

Conclusion: In our study, patients with spondyloarthritis who have a vitamin D deficit correlate with presenting disease activity (BASDAI ≥ 4). Therefore, inflammation along with increased bone turnover and low levels of vitamin D could be related to the pathophysiology of osteoporosis related to spondyloarthritis, and may adversely affect the patient's functional status and quality of life.

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AB1252 FUNCTIONAL STATUS CHANGES ASSOCIATED WITH INFLAMMATORY ARTHRITIS IN REPUBLIC OF MOLDOVA

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Background: Inflammatory joint disease is a burden to the patient and society, due to medical costs and the impact it has on the health-related quality of life. Functional status plays a significant role in quality of life impairment.

Objectives: To study and compare functional status changes between different inflammatory joint diseases and degenerative joint disease.

Methods: 1500 patients with inflammatory joint disease and 400 patients with degenerative joint disease were included in this study. In the first group, 645 (43.0%) were diagnosed with rheumatoid arthritis, 330 (22.0%) - psoriatic arthritis, 100 (6.7%) - ankylosing spondylitis, 200 (13.3%) - axial spondyloarthritis, 135 (9.0%) - gout, 20 (1.3%) - other crystal arthritis, 45 (3.0%) - early arthritis and 25 (1.7%) with other arthritis. Physical exam with functional status was assessment were performed. Descriptive statistics and Mann-Whitney U tests were used to compare the study groups, as well as the subgroups within the inflammatory disease group.

Results: Both groups were comparable according to sex, with a predominance of female sex ($\chi^2 = 86.4$ and 30.74 respectively, $p < 0.001$), and no difference in sex distribution (mean ranks of U test - 950.98 and 967.44 , $p = 0.524$). Mean age was significantly lower in the inflammatory joint disease group (44.76 vs 60.19 , $p < 0.001$). The Mann-Whitney U test showed a significantly greater mean rank in the inflammatory disease group (999.07 vs 790.66 , $p < 0.001$), suggesting an overall higher functional class, and thus worse functional status in the inflammatory joint disease group. Further analysis using the same method, between subgroups in the inflammatory joint disease group, showed a higher mean rank (worse functional status) in patients with rheumatoid arthritis, when compared with psoriatic arthritis (501.95 vs 460.73 , $p < 0.05$) and early arthritis (352.24 and 248.83 , $p < 0.001$). Psoriatic arthritis showed a higher mean rank, compared to axial spondyloarthritis (282.88 vs 254.97 $p < 0.05$) and early arthritis (193.34 vs 148.83 , $p < 0.01$). Gout patients showed a higher mean rank (worse functional status), when compared to rheumatoid arthritis (453.65 vs 377.28 , $p < 0.001$), psoriatic arthritis (281.33 vs 213.23 , $p < 0.001$), ankylosing spondylitis (127.07 vs 105.75 , $p < 0.05$), axial spondyloarthritis (184.67 vs 156.75 , $p < 0.01$) and early arthritis (101.70 vs 56.89 , $p < 0.001$), thus making it the subgroup associated with the poorest functional status. Ankylosing spondylitis showed a higher mean rank, when compared to psoriatic arthritis (238.13 vs 208.64 , $p < 0.05$), axial spondyloarthritis (151.75 vs 129.88 , $p < 0.05$) and early arthritis (81.63 vs 53.83 , $p < 0.001$). Axial spondyloarthritis and other crystalline arthritis subgroups both showed higher mean ranks compared to early arthritis (130.0 vs 91.89 and 43.2 vs 28.56 respectively, $p < 0.01$), making early arthritis the subgroup associated with the best functional status. No significant differences were found when comparing rheumatoid arthritis with ankylosing spondylitis, axial spondyloarthritis and other crystalline arthritis.

Conclusion: This is the first study conducted on a national scale to assess the impact of inflammatory joint disease on functional status. Inflammatory joint disease involved a younger age group, when compared to degenerative joint disease, with a higher impact on the functional status. Interestingly, gout was associated with one of the poorest functional status, suggesting the need for a more aggressive approach toward this disease. After gout, a significantly impaired functional status was associated with rheumatoid arthritis, ankylosing spondylitis and axial spondyloarthritis, whereas early arthritis was generally associated with a better functional status, when compared to other inflammatory diseases.

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AB1253 DETERMINATION OF RISK FACTORS OF DEVELOPMENT OF HYPERURICEMIA IN PROFESSIONAL ATHLETES IN SOME SPORTS

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Background: Prevalence of hyperuricemia worldwide has been steadily increasing over the past decades and becomes higher with age.

The number of studies on the prevalence of hyperuricemia and its role in development of diseases in some social groups is low, yet there is data on its high frequency in professional athletes.

Objectives: to assess impact of certain factors upon the risk of development of hyperuricemia in professional athletes in some sports.

Methods: the study was performed as retrospective. Out of 753 athletes in six sports, 267 athletes who met the study criteria were selected.

The inclusion criteria: professional athletes aged 18-40, serum uric acid level $< 360 \mu\text{mol/L}$, according to screening tests. The exclusion criterion was refusal to undergo a thorough medical examination.

Out of 753 athletes, 228 (30.3%) showed high uric acid level in their screening test, 258 (34.3%) athletes refused to undergo a medical examination. 267 people were included in the study, 130 men (48.7%) and 137 women (51.3%), with the mean age of 24.4 ± 5.2 years and the average observation period of 3.0 ± 0.3 years.

Parameters under investigation: anthropometric measurements, laboratory tests (serum levels of lactate, creatinine, crude protein, triglycerides, thyroid-stimulating hormone (TSH), AST, ALT, myoglobin, testosterone, uric acid (UA)), glomerular filtration rate (GFR) (using the MDRD formula) with subsequent statistical analysis.

Hyperuricemia was defined as SUA level $> 360 \mu\text{mol/L}$. Hypercholesterolemia - as serum cholesterol level $> 5.0 \mu\text{mol/L}$, hypertriglyceridemia - as serum TG level $> 1.7 \text{ mmol/L}$. High serum creatinine level as $> 100 \mu\text{mol/L}$.

Statistical analysis was conducted using the applied programs package of descriptive statistics STATISTICA 12.0 (StatSoft, Inc., USA).

Results: Hyperuricemia developed in 60 athletes (22.5%), including 51 (39.2%) men and 9 (6.6%) women.

The frequency of risk factor detection was the following: hypercholesterolemia was detected in 91 (34%) professional athletes, hypertriglyceridemia - in 10 (3.7%), reduction in GFR $< 100 \text{ mL/min}$ - in 46 (17.2%), BMI $> 25 \text{ kg/m}^2$ - in 65 (24.3%), BMI $> 30 \text{ kg/m}^2$ - in 3 (1.1%), arterial hypertension in 0 (0%) professional athletes.

The univariate analysis showed that out of all the factors under investigation, the following factors were significantly associated with the development of hyperuricemia: male sex (OR 9.181, 95% CI (4.285;19.674) $p < 0.001$), hypertriglyceridemia (OR - 4.857, 95% CI (1.056;22.339) $p = 0.042$), BMI $> 25 \text{ kg/m}^2$ (OR - 2.470, 95% CI (1.243;4.909) $p = 0.01$), increased level of CPK (OR - 2.247, 95% CI (1.230;4.105) $p = 0.008$). Age > 25 years was associated with lower risk of development of hyperuricemia.

According to the multifactor analysis, development of hyperuricemia is associated with male sex (OR - 13.4, 95% CI (3.6;49.6) $p = 0.00012$) and BMI $> 25 \text{ kg/m}^2$ (OR - 2.4, 95% CI (1.02;5.69) $p = 0.04$).

Conclusion: hyperuricemia developed in professional athletes in 22.5% cases in 3.0 years. This study confirms high risk of development of hyperuricemia in professional athletes (22.5% cases in the 3-year observation period) along with low frequency of many traditional risk factors (obesity, hypercholesterolemia, hypertriglyceridemia, chronic kidney disease), which can be linked to the peculiarities of diet. This fact calls for a detailed investigation of the dietary intake of athletes with the purpose of its optimization.

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