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AB1256 HIGH PREVALENCE OF DEPRESSION IN RHEUMATIC DISEASES: CASE-CONTROL STUDY

Dionicio Ángel Galarza-Delgado¹, José Ramón Azpiri-López², Iris Jazmin Colunga-Pedraza¹, Karla Paola Cuéllar-Calderón¹, Ileana Cecilia Reynosa-Silva¹, Marielva Castro-González¹, Carolina Marlene Martínez-Flores², Raymundo Pineda¹. ¹Hospital Universitario Dr José Eleuterio Gonzalez, Rheumatology, Monterrey, Mexico; ²Hospital Universitario Dr José Eleuterio Gonzalez, Cardiology, Monterrey, Mexico

Background: Prevalence of depression is higher in subjects with rheumatic diseases (RD) when compared to other general medical conditions. It's associated with chronic pain and long-term medical treatment. The Patient Health Questionnaire 9 (PHQ-9) is an extensively validated screening tool, with a negative predictive value of 99%; it has several advantages, like being self-applied and able to be used by any clinician. Currently there are no trials using this screening tool in Mexican rheumatic patients.

Objectives: To determine the prevalence of depression in a group of rheumatic subjects and compare it to non-rheumatic controls.

Methods: An observational, cross-sectional study was designed. Subjects with RD attending an outpatient clinic were consecutively recruited. A complete clinical history with information about exercise history, and the PHQ-9 screening tool were performed to every subject. Subjects without RD were recruited as controls. Descriptive analysis was done using frequencies (%) and median (q25-q75). Comparisons were done using Chi-square and Mann-U Whitney's test, considering only $p < 0.05$ as significant.

Results: A total of 269 subjects were included. Demographic characteristics are shown in Table 1. In the RD group, a higher percentage were female ($p < 0.001$) and had a higher median age ($p < 0.001$). A higher prevalence of depression was found in the RD group ($p < 0.002$). Regarding exercise history, subjects with an inactive lifestyle had a higher prevalence of depression ($p < 0.001$). This remained significant after evaluating only subjects with RD ($p < 0.007$) and controls ($p < 0.003$).

Abstract AB1256 Table 1. Demographic Characteristics

	Rheumatic diseases (n=195)	Controls (n=74)	p
Female, n (%)	175 (89.7)	52 (70.3)	<0.001
Age, n (%)	58 (47-65)	46 (30-60)	<0.001
Hypertension, n (%)	46 (24.3)	18 (24.7)	NS
T2DM, n (%)	22 (11.7)	13 (17.8)	NS
Dyslipidemia, n (%)	59 (31.7)	23 (32.4)	NS
Active smoking, n (%)	11 (5.9)	8 (11.1)	NS
Inactive Lifestyle, n (%)	103 (55.1)	33 (48.5)	NS
RA, n (%)	106 (54.3)	-	-
OA, n (%)	32 (16.4)	-	-
LES, n (%)	7 (3.5)	-	-
Sjogren Syndrome, n (%)	7 (3.5)	-	-
Fibromyalgia, n (%)	9 (4.6)	-	-
Ankylosis spondylitis, n (%)	5 (1.9)	-	-
PsA, n (%)	3 (1.1)	-	-
Scleroderma, n (%)	4 (2)	-	-
Other RD, n (%)	22 (11.2)	-	-

Abstract AB1256 Table 2. Patient Health Questionnaire (PHQ-9)

Classification Cut-off point	Rheumatic diseases N=195	Controls N=74	p
Normal 0-5, n (%)	84 (43.1)	49 (66.2)	0.003
Mild 6-9, n (%)	41 (21)	11 (14.9)	
Major Depression ≥ 10 , n (%)	70 (35.9)	14 (18.6)	

Conclusion: Patients with RD have a higher prevalence of depression than non-rheumatic controls ($p < 0.001$). An inactive lifestyle was associated with a higher prevalence of depression in our cohort, both in RD subjects and in controls ($p < 0.001$). This is the first study that evaluates the PHQ-9 screening tool in Mexican patients with RD. The physicians should be aware of it and use screening tools to detect depression disorders and provide an adequate treatment.

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AB1257 CARDIOVASCULAR RISK FACTORS IN GOUT COMPARED TO AS, PSA AND RA – RESULTS FROM A QUESTIONNAIRE STUDY

Mats Dehlin¹, Ulrika Bergsten², Eva Klingberg¹, Anton Landgren¹, Lennart T. H. Jacobsson¹. ¹Sahlgrenska Academy, Institution of Medicine, Dept of Rheumatology and Inflammation Research, Gothenburg, Sweden; ²Rand Department at Region Halland, Halmstad, Sweden

Background: Increased risk for cardiovascular disease (CVD) is a hallmark for many rheumatic diseases including gout, ankylosing spondylitis (AS), psoriatic arthritis (PsA) and rheumatoid arthritis (RA). This is likely explained by a combination of increased occurrence of CVD risk factors (CVDRF) and chronic inflammation and in gout possibly by increased serum urate levels.

Objectives: To compare the prevalence of CVRFs and CVD in gout, AS, PsA and RA.

Methods: All individuals aged ≥ 18 years with at least one ICD-10 diagnosis of gout (M10), AS (M459), PsA (M073) and RA (M059/M060) recorded by a physician during a two year period (Jan 2015 through Feb 2017) were identified at 12 primary care centers and three rheumatology units in the Western Sweden Health Care Region. A total of 1589 gout, 1095 AS, 1200 PsA and 1246 RA subjects were sent a questionnaire which included questions on demographics, CVRFs (smoking, alcohol consumption, physical activity (PA)) and comorbidities (diabetes (DM), hypertension (HT), dyslipidemia (DL), acute coronary syndrome (ACS) and stroke). High alcohol intake was defined as > 4 std drinks/week. Low PA was defined as ≤ 3 hours of moderate PA/week. Primary non-responders received a second mailing of the questionnaire. All prevalences were indirectly age standardized (IAS) to the population of Sweden 2017, due to the differences in age distribution between the diseases. Chi square test with significance level .05 was performed. IAS prevalences for BMI, PA, DM and HT for the general population (GP) was retrieved from the National public health survey from 2015 which was sent to more than 100 000 randomly selected citizens in Sweden aged 16-84.

Results: Response rates ranged from 53.6% (AS) to 59.6% (RA) and after excluding subjects who had not provided complete information on the evaluated variables we included 2437 individuals. The gout and RA

patients were older (mean age 71 (SD 12) and 66 (SD 13) years respectively) compared to AS and PsA (mean age 50 (SD 14) and 55 (SD 13) years respectively). When adjusting for these differences by IAS by sex, both prevalent CVD (stroke, ACS) and all traditional risk factors were more common in gout compared to RA, AS or PsA (Table 1+2), except for alcohol intake in women, where highest exposure was seen in PsA (Table 2). The male AS patients displayed the highest PA level and the lowest prevalence of stroke (table 1). Smoking was least common in male PsA and female AS and RA patients (table 1+2).

Males	Gout, n=582, prevalence %	AS, n=273, prevalence %	PsA, n=268, prevalence %	RA, n=315, prevalence %	p-value*	GP, n=23177, prevalence %
BMI ≥25	85.3	51.5	59.0	65.9	< 0.0001	56.2
PA, low	61.9	44.0	54.8	58.0	0.0001	42.5
Alcohol, high	43.3	20.0	28.3	16.5	< 0.0001	N/A
Smoking, ever	48.5	53.4	35.9	46.6	0.0003	N/A
DM	14.2	4.8	8.4	8.7	0.0001	6.0
HT	49.2	23.9	32.9	29.2	< 0.0001	18.7
DL	25.3	9.6	11.2	13.1	< 0.0001	N/A
Stroke	7.7	0.9	4.1	4.9	0.0005	N/A
ACS	7.7	3.1	6.1	6.4	0.6	N/A

Age-standardized prevalences of CVD riskfactors and outcomes in males, *Chi-square comparing gout, AS, PsA and RA

Females	Gout, n=134, prevalence %	AS, n=215, prevalence %	PsA, n=305, prevalence %	RA, n=345, prevalence %	p-value*	GP, n=26714, prevalence %
BMI ≥25	87.3	40.8	60.0	45.9	< 0.0001	43.1
PA, low	74.8	48.3	54.3	52.6	<0.0001	46.5
Alcohol, high	7.0	6.4	14.2	6.9	0.003	N/A
Smoking, ever	56.7	37.8	56.8	38.0	< 0.0001	N/A
DM	14.9	2.3	4.9	4.2	< 0.0001	4.4
HT	56.8	20.3	27.5	24.4	< 0.0001	17.6
DL	26.7	7.4	10.5	9.7	< 0.0001	N/A
Stroke	3.7	0.8	0.6	1.7	0.09	N/A
ACS	3.6	0.0	1.8	2.5	0.2	N/A

Age-standardized prevalences of CVD riskfactors and outcomes in females, *Chi-square comparing gout, AS, PsA and RA

Conclusion: Gout patients display the highest prevalence of CVRFs in both men and women compared to AS, PsA and RA. Thus, addressing CVDRFs is of particular importance in patients with gout.

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AB1258

THE 10 YEAREXPERIENCE OF IDENTIFYING AND MONITORING INDIVIDUALS AT RISK OF RA IN AN ARTHRITIS PREVENTION CLINIC

Laurence Duquenne^{1,2}, Kulveer Mankia^{1,2}, Jacqueline Nam^{1,2}, Leticia Garcia-Montoya^{1,2}, Peta Pentony^{1,2}, Andrea Dimatteo^{1,2}, Laura Hunt^{1,2}, Paul Emery^{1,2}.

¹Leeds Institute of Rheumatic and Musculoskeletal Medicine, Leeds, United Kingdom; ²NIHR Leeds Biomedical Research Centre, Leeds, United Kingdom

Background: Anti-cyclic citrullinated protein antibodies (anti-CCP) are highly specific for rheumatoid arthritis (RA) and may appear more than 10years before the disease. As the test has become more accessible, many patients without clinical synovitis are being globally tested.

Objectives: We have developed in Leeds a prevention study clinic for referrals from individuals identified through our primary care research network alongside the patients from secondary care referrals, aiming for an early identification of inflammatory arthritis (IA)[1].

Methods: From June 2008 to December 2018, individuals from our primary care network with new musculo-skeletal symptoms were invited to be tested. All anti-CCP tests were performed centrally in our Rheumatology Department in Leeds (LIRMM), using a standard Anti-CCP2 assay (immunocap method, Phadia assay). Individuals from primary or secondary

care who were tested positive for anti-CCP antibodies (CCP positive) were invited to Leeds and followed prospectively in a research, observational study until progression to IA.

Results: As shown in figure 1, the number of patients referred to our study from either primary or secondary care has been increasing gradually. Over the last year, the overall referrals reached 2368 participants, 115 of them from secondary care and 2253 from primary care.

Of the 901 CCP positive individuals, 479 met the inclusion criteria and accepted to participate to the study (Table 1). Actually, the mean follow-up time of the overall cohort is 98.5weeks (SD 105.55) with a cumulative time of follow-up of over 50 000 weeks. There is a female predominance of 72.1% and a mean age of 50.3 years (SD 13.51) at baseline. Of the 165 participants that have been withdrawn from the study, 134 developed IA after a mean time of 83.8 weeks (28.0% of the overall cohort). Currently, 353 anti-CCP positive patients are still being followed. Age and sex of the patients who progressed are similar to the ones still in the study (respectively p=0.798 and p=0.326).

Conclusion: Leeds Teaching Hospital and LIRMM have now been following patients at risk of progressing to IA for more than 10 years. The steady increase in recruitment from both primary care and secondary care centres confers a viable base for recruitment. As prevention is a key aspect in global Health management, our study is a sustainable model for identifying at-risk subjects of progression, a necessary step towards prevention. This increase in overall referrals correlates with a need of recommendation regarding management of patients, especially those at high risk.

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Figure 1

Table 1. Demographics

	Overall cohort	Progressors (84% of total withdrawn (n=165))	Ongoing follow-up
N	479	136 (26.1%)	314
Mean follow-up (weeks)	98.5 (SD 105.55)	83.83 (SD 90.87)	105.72 (SD111.65)
CCP titre	High: 59.9% (n=288) Low: 36.4% (n=175) Neg: 3.11% (n=15)*	High: 89.7% (n=122) Low: 9.6% (n=13) RF control: 0.7% (n=1)	High: 49.4% (n=155) Low: 49.4% (n=155) Neg: 1.3% (n=4)
Gender	F 72.1% (n=347) M 27.9% (n=134)	F 68.4% (n=93) M 31.6% (n=43)	F 72.9% (n=229) M 27.1% (n=85)
Age	50.34 (SD13.51)	52.8 (SD 13.05)	49.84 (SD13.56)

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