anti-CarP IgA isoform was >125 U/mL, for the IgG isoform was >90 U/mL, and for the IgM isoform was >300 U/mL. The FDRs were classified as: suspicious arthralgia for progression according to Van Steenbergen criteria; undifferentiated arthritis (UA) and RA according to ACR/EULAR 2010; and soft tissue rheumatic diseases.

Results: A total of 144 FDRs from 99 RA patients were enrolled. The demographic characteristics are shown in Table 1. The prevalence (Table 2) for anti-CarP was 2.8% for IgA, 4.2% for IgG, whereas IgM was not detected. The serologic association was for RF/ACPA 4.48%, RF/anti-CarP 2.7%, FR 64.5%, ACPA 1.3%, ACPA/anti-CarP 0.69%, anti-CarP 3.4%, and no RF/ACPA/anti-CarP was observed.

The group of suspicious arthralgia for progression had 2 subjects positive for IgG anti-CarP, the group of UA had 1 subject positive for IgA anti-CarP, albeit no anti-CarP for the RA group was present. Soft tissue rheumatic diseases group had 5 subjects positive for IgG anti-CarP, while the asymptomatic group had 2 subjects positive for IgA anti-CarP.

Table 1

Population, n (%)	144 (100%)
Age (years), median (IQR)	45.25 (18-76)
Weight (kg), median (IQR)	70 (42-117)
Height (meters), median (IQR)	1.61 (1.44-1.88)
BMI, median (IQR)	26.19 (16.7-47.3)
Female, n (%)	119 (82%)
HAQ, median (IQR)	0.29 (0-2.15)

IQR: interquartile range, Kg: kilograms; BMI: body mass index, HAQ: Health Assessment Questionnaire

Abstract AB1277 Table 2

	POSITIVE, n (%)	MIN/MAX	MEDIAN
CRP, mg/dL	19 (13%)	0.0-2.27	0.36
ESR, mm/H; mean (SD)	37 (25.3%)	1-72	13.0 (11.95)
Anti-CarP, U/mL			
IgA	4 (2.8%)	0.0-818	2.0
IgM	0 (0.0%)	0.0-56	5.45
IgG	6 (4.2%)	0.0-187	8.0
Rheumatoid Factor, U/mL			
IgA	31 (21.5%)	1-219	6.96
IgM	64 (44.4%)	1-205	15
IgG	14 (9.7%)	1-160	3.04
ACPA-IgG, U/mL	10 (7%)	1-200	1.21

CRP: C Reactive Protein; ESR: erythrocyte Sedimentation Ratio; anti-CarP: Anti-Carbamylated Protein; SD: Standard Deviation; ACPA: anti-Citrullinated Peptides Antibodies.

Conclusion: Even though we used the 3 isoforms of anti-CarP antibodies, the prevalence of these antibodies in our cohort showed less positivity than other cohorts, who only detected the IgG isoform, worldwide.

REFERENCES

- [1] Ingris Pelaez-Ballestas, et al. Epidemiology of the Rheumatic Diseases in Mexico. A Study of 5 Regions Based on the COPCORD Methodology. *J Rheumatol* 2011; 38 Suppl 86:3-6.
- [2] Jing Shi, et al. The specificity of anti-carbamylated protein antibodies for rheumatoid arthritis in a setting of early arthritis. *Arthritis Research & Therapy* (2015) 17:339.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.1452

AB1278

ANNOUNCEMENT OF CHRONIC RHEUMATIC INFLAMMATORY DISEASE: THE RHEUMATOLOGIST'S POINT OF VIEW

patrick Lemesle¹, Xavier Grapton², Nabil Bouhedja³. ¹Centre Hospitalier Rives de Seine, Site de Courbevoie, 92, Courbevoie, France; ²PRIVATE PRACTICE, ISSY LES MOULINEAUX, France; ³PRIVATE PRACTICE, LA GARENNE COLOMBES, France

Background: The onset of a chronic rheumatic inflammatory disease (CRD) is a turmoil in a patient's life. The announcement, first step of information (a legal and ethical necessity), will leave a lasting impression in a patient's history.

Objectives: Determine the rheumatologist's methods to reveal a potentially disabling disease with an uncertain prognosis. Compare, in the discussion chapter, the rheumatologist's vision and the patient's experience at the time of the announcement.

Methods: 39 private practice rheumatologists from the CREER group. 52% women, mean age 59 years. 222 CRD including 56% rheumatoid arthritis (RA), 27% spondyloarthritis (SPA), 17% others. Survey including

31 questions. Direct eye contact 89%, gesture 56%, modulated tone 49%, silence 36%, compassionate approach 26%. Gaining confidence by : availability, listening to, explanations, empathy, frankness.

The rheumatologist thinks that he is reassuring and comforting 100%, empathic 98%, transparent 72%. He calms 42%, supports, is optimistic because he is sensitive to the patient's reactions 61%, but sometimes destabilized by a treatment refusal. He mentions life quality 51%, invites him to question it 58%, encourages him on a mutual management of the CRD 92% and insists on treatment compliance. He gives few documents, rarely mentions patient organizations, speaks about chronic disorder status, informs the treating physician and is always available.

Results: The announcement is different depending on : the type of CRD (59%), its presentation, the prognosis (29%), the induced emotion, the patient's profile, 82% (intellect 41%, personality 22%, age 16%), the information to provide (course, treatment).

Duration of consultation : long 51%, doubled 64%. Time given to assimilate the information 93%, to discuss 90%. Explanations given 100%, rephrased 32%, repeated 27%, verified 9%.

Announcement unchanged if patient alone or accompanied; handling adapted to its degree of worry. If patient is anxious, depressive, rebellious or denying : see him again 29%, re-explain 22%, listen to him, adapt.

When comparing the rheumatologist's and the patient's assessment about the announcement, there is globally an agreement, but it's less affirmative for all the items. However, the patient thinks his rheumatologist more frank than he really is. Indeed, he announces with feeling and spends time on it, but not enough for the patient. He is less comforting, reassuring and explaining what he believes. He mentions the treatment inconveniences and life quality, which is well perceived. But he should guide more to annex treatments. For all the suggested items, the SPA patients are less optimistic than the RA patients.

Conclusion: the announcement takes into account above all the patient's profile, the type and the seriousness of the CRD. The rheumatologist dedicates a lot of time on the announcement, which is made step by step, but still too fast for the patient. He explains, listens to, reassures, comforts by using human methods to gain the patient's confidence. He supports him and helps him to manage his disease. He involves the patient and stays available. The patient feels well informed and taken care of in his entirety with empathy.

REFERENCES

- [1] CREER group

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.2506

AB1279

PHYSICAL ACTIVITY LEVELS AND ATTITUDES IN PATIENTS WITH AXIAL AND PERIPHERAL SPONDYLOARTHRITIS

Shao-Hsien Liu, Divya Shridharmurthy, Kate Lapane, Stephen Morais, Catherine Dubé, Jonathan Kay. *University of Massachusetts Medical School, Worcester, United States of America*

Background: Spondylarthritis is one of the common inflammatory rheumatic diseases in adults, with an overall prevalence of 0.5 to 1%. Based on clinical manifestations and the Assessment in Spondylarthrosis International Society (ASAS) criteria, spondyloarthritis can be distinguished as predominately axial or peripheral. Despite the health-related benefits of regular physical activity, patients with spondyloarthritis, are generally less active than those without disease. Studies evaluating the differences in physical activity levels and attitudes towards exercise of patients with axial and peripheral spondyloarthritis are limited.

Objectives: To characterize and compare self-reported physical activity and attitudes towards exercise among patients with axial and peripheral spondyloarthritis.

Methods: We used baseline information from an on-going, longitudinal, single-site, prospective cohort study consisting of 244 patients with spondyloarthritis including psoriatic arthritis, ankylosing spondylitis, and other spondyloarthropathies. Attitudes and beliefs towards exercise were assessed from 5 domains including: 1) general attitude towards exercise; 2) support from other people; 3) benefits in exercise/physically active; 4) concerns about being active; and 5) exercise/physical activity behavior. A continuous scale (range: 0 -100) was used to evaluate attitudes and beliefs towards exercise. High scores indicated that the individual found exercise to be beneficial and/or liked engaging in physical activity. Physical activity was evaluated using the Nurses' Health Study physical activity questionnaire II (NHSPAQ II). Physical activity levels were assessed using