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

the total metabolic equivalent (MET) to incorporate the frequency, duration and intensity by different type of activities. Minutes spent in each level of activity (e.g., sedentary, light, moderate, and vigorous) were then summed for each week. Adjusted multivariable linear models estimated the relationship between physical activity levels and disease status.

Results: Overall, nearly 80% of the study sample had predominantly peripheral spondyloarthritis. The average age for participants with peripheral disease was 53.2 (standard deviation (SD):12.9) and for those with axial disease was 44.2 (SD: 12.4). Most of the study participants were men, white, non-Hispanic, married, and had attended at least some college, regardless of predominant joint distribution (peripheral versus axial). While the median for general attitude towards regular exercise in participants with peripheral disease was 88.5, the median score was 81.0 in participants with axial disease. The median score regarding benefits of exercise/physical activity to improve general function was 97.0 among participants with peripheral disease and 95.5 among those with axial disease; the median score for pain relief was 67.0 in participants with peripheral disease and 66.5 for those with axial disease. Regardless of predominant joint distribution, walking, bicycling, and swimming were the most common types of exercise. Compared to participants with predominantly peripheral disease, participants with axial disease spent more time per week engaging in light physical activities (adjusted β : 13.0 hrs/week; 95% confidence interval: 0.4 to 25.6 hrs/week) after adjusting for sociodemographic and clinical factors.

Conclusion: Patients with spondyloarthritis have positive attitudes towards physical activity/exercise, regardless of their predominant joint distribution, and believe that these activities improve general function and, to a lesser extent, relieve pain. However, patients with axial disease spend more time per week engaging in light physical activities than do those with peripheral disease.

Acknowledgement: This work was supported by a generous donation from Timothy S. and Elaine L. Peterson.

Disclosure of Interests: Shao-Hsien Liu Grant/research support from: Novartis, Divya Shridharmurthy: None declared, Kate Lapane Grant/research support from: Novartis, Merck, Pfizer, Janssen, Consultant for: Pfizer, Stephen Morais: None declared, Catherine Dubé Grant/research support from: Novartis, Jonathan Kay Grant/research support from: Gilead Sciences, Pfizer, UCB Pharma, Consultant for: AbbVie, Boehringer Ingelheim GmbH, Celltrion Healthcare, Merck Sharp & Dohme Corp., Novartis Pharmaceuticals, Pfizer, Samsung Bioepis, Sandoz, UCB Pharma
DOI: 10.1136/annrheumdis-2019-eular.4421

AB1280 EPIDEMIOLOGICAL PROFILE OF PATIENTS WITH FIBROMYALGIA IN A SPECIALIZED INSTITUTE IN MEDELLÍN, COLOMBIA 2010–2016

Marcela Henao Pérez¹, Diana Carolina López Medina¹, Alejandra Arboleda Ramírez², Julian Zea Osorio¹, Sara Bedoya Monsalve¹, Infettare.

¹Universidad Cooperativa de Colombia, Medellín, Colombia; ²Instituto Neurológico de Colombia, Medellín, Colombia

Background: Fibromyalgia is a common cause of chronic musculoskeletal pain in the world, with diverse clinical manifestations and with a ruinous effect on the quality of life of patients. The estimations of prevalence in the general population are very variable (0.2% - 6.4%) as well as the clinical presentation.

Objectives: This study aims to describe the sociodemographic and clinical characteristics of patients with fibromyalgia treated in a specialized institution between 2010 and 2016, in Medellín, Colombia.

Methods: We performed a retrospective, descriptive, secondary source study of patients diagnosed with fibromyalgia from a specialized institution between 2010 and 2016. Descriptive statistics and period prevalence tools were applied for the variables studied, among which was evaluated the use of the diagnostic criteria (1990 or 2010) of the American College of Rheumatology.

Results: We evaluated 1106 records of patients diagnosed with fibromyalgia. The median age was 54 years (IQR 16), the age of greatest presentation is between 40 and 65 years for both sexes, 95.1% were women and a 51.1% were married or living with their partner. 23.6% of the patients had a basic and middle level education (secondary and technological level), 93% of the population came from the department of Antioquia (for a prevalence for this institution in the period 2010 to 2016 of 0.017%), and 54% resided in the city of Medellín. The proportion of people with low and medium low socioeconomic status was 26.3%, while 41.4% reported being active in a job. The symptoms most frequently presented among the patients were myalgia (70.2%), sleep disturbances (59.9%), chronic fatigue (48.5%), headache (47.3%) and muscular weakness (40.5%). When analyzing by sex, headaches were more frequent in

women (48.8%) than in men (24.1%). The most commonly reported comorbidities were psychiatric disorders (31.1%, where depression was the most recorded with 24.1%), migraine (30.9%) and hypertension (27.9%). The most used criteria to make the diagnosis of fibromyalgia were those of 1990 with 62.2%. Regarding treatment, the most used were serotonin reuptake inhibitors and dual inhibitors (52.6%), along with acetaminophen (41.2%) and pregabalin (39%); only 8.2% of patients received non-pharmacological interventions (physical and psychological therapy).

Conclusion: Fibromyalgia is an important pathology in specialized medical consultation, accompanied by myalgia, sleep disturbances, chronic fatigue, headaches and muscle weakness. Psychiatric pathologies are the most frequently associated comorbidities and the 2010 criteria of the American College of Rheumatology are not yet widely applied. The treatment of fibromyalgia is complex and probably more effective with a transdisciplinary approach involving both pharmacological and non-pharmacological interventions.

REFERENCES

- [1] Wolfe F, Walitt B, Perrot S, Rasker JJ, Häuser W. Fibromyalgia diagnosis and biased assessment: Sex, prevalence and bias. *PLoS One* [Internet]. Public Library of Science; 2018 Sep 13; 13(9): e0203755.
- [2] Marques AP, Santo AdSdE, Berssaneti AA, Matsutani LA, Yuan SLK. Prevalence of fibromyalgia: literature review update. *Revista Brasileira de Reumatologia* (English Edition). 2017;57(4):356-63.
- [3] Häuser W, Ablin J, Fitzcharles M-A, Littlejohn G, Luciano JV, Usui C, et al. *Fibromyalgia. Nature Reviews Disease Primers*. 2015;1:15022.
- [4] Queiroz LP. Worldwide epidemiology of fibromyalgia. *Current pain and headache reports*. 2013;17(8):356.

Acknowledgement: This study was financed with funds from CONADI of the Universidad Cooperativa de Colombia. [Reference: 2042]

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.1296

AB1281 USAGE OF PROOF-BP TO PREDICT HYPERTENSION IN MEXICAN-MESTIZO RHEUMATIC PATIENTS

Dionicio Ángel Galarza-Delgado¹, José Ramón Azpiri-López², Iris Jazmin Colunga-Pedraza¹, Carolina Marlene Martínez-Flores², Karla Paola Cuéllar-Calderón¹, Ileana Cecilia Reynosa-Silva¹, Marielva Castro-González¹, Raymundo Pineda².

¹Hospital Universitario, "Dr. José Eleuterio González", UANL, Rheumatology, Monterrey, Mexico; ²Hospital Universitario, "Dr. José Eleuterio González", UANL, Cardiology, Monterrey, Mexico

Background: Subjects with rheumatic diseases have an increased risk of cardiovascular morbimortality. Hypertension (HTN) is a key modifiable risk factor for cardiovascular events (1). A recently published and validated prediction model (Predicting Out-of-Office Blood Pressure, PROOF-BP) has been proposed as a tool to improve diagnosis of HTN, and detection of out-of-office HTN in subjects with a previous diagnosis, with a c-statistic (AUC) of 0.86 in non-rheumatic subjects (2). This model has not been explored in rheumatic patients.

Objectives: To evaluate the diagnostic performance of the PROOF-BP algorithm for the prediction of HTN in subjects with/without rheumatic diseases.

Methods: A cross-sectional, observational trial was designed. Subjects were recruited at a rheumatology outpatient clinic in northeastern Mexico. Subjects with/without rheumatologic conditions were recruited. Complete clinical history with somatometry of each subject was registered. BP was measured by a physician 3 times to each participant using current recommendations, with an OMRON HEM-7121 BP monitor. Calculations using the PROOF-BP online site were done, and risk categories were assigned to each subject using their predicted out-of-office BP: low (<130/80 mmHg), medium (130/80-145/90 mmHg) and high risk (>145/90 mmHg). Subjects in the medium and high risk strata were then asked to return for further evaluation and additional BP measurement, to define each diagnosis of HTN. We used frequencies (%) and median (q25-q75) for descriptive analysis. Diagnostic accuracy of each category was determined using 2 x 2 tables.

Results: A total of 217 subjects were included. Baseline characteristics are shown in Table 1. The most frequent rheumatic disease was RA (n=78, 35.9%). Using PROOF-BP, 84 (38.7%) subjects were stratified as medium or high risk. Of these, only 36 (42.8%) returned for evaluation. A final diagnosis of HTN was attained in 14 (38.8%) of those who returned. Diagnostic performances of the low and high risk categories are shown in Table 2. In 21 (67.7%) cases of the medium risk category the