AB1286

EVALUATION OF CARDIOVASCULAR RISK FACTORS AND PREVALENCE OF METABOLIC SYNDROME IN PATIENTS WITH DIAGNOSIS OF ANKYLOSING SPONDYLITIS:

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Background: Cardiovascular events are the main causes of mortality in patients with Ankylosing Spondylitis. In addition, a higher prevalence of Metabolic Syndrome is reported in this group. With immunobiological therapy, much progress has been made in controlling the inflammatory process, but the cardiovascular risk remains high.

Objectives: To evaluate the prevalence of cardiovascular risk factors and Metabolic Syndrome in patients with Ankylosing Spondylitis at the Rheumatology Outpatient Clinic of HC-UFG and to correlate them with epidemiological, clinical, laboratory and radiographic characteristics of the disease.

Methods: Data from 59 patients were collected in medical records between July and August 2018. Clinical characteristics, cardiovascular risk factors and metabolic components were analyzed. Descriptive analyzes of the data were made, prevalences and their reasons were calculated. The associations between variables were assessed by chi-square test and Fisher's exact test.

Results: 81.4% were male, 67.8% self-denominated non-whites, average age 46.7 years. Isolated axial joint involvement was the most frequently observed (54.2%). Enthesopathic lesions were identified in 30.51% of the cases. Uveitis had a higher prevalence (22.02%), 4.2 times higher in the subgroup with HLA-B27 positive ($p=0.0002$). HLA-B27 was present in 67.8%. Advanced sacroiliitis (grades 3 and 4) and syndesmophytosis were identified in 61.1% and 49.2%, respectively, but didn't presented significant correlation with the presence of HLA-B27. 64.4% were using anti-TNF alone or in combination. The majority of the patients (72.9%) were sedentary. Clinical comorbidities were reported in 66.1% of the cases, with dyslipidemia (45.8%), systemic arterial hypertension (37.6%) and diabetes mellitus (13.6%) being the most common. Metabolic Syndrome was diagnosed in 23.7% of the samples. Normal levels of triglycerides and fasting glycemia and lower prevalence of Metabolic Syndrome had a statistically significant association with the presence of HLA-B27 ($p=0.006$; 0.026 and 0.014, respectively). Patients with HLA-B27 present had 61% lower frequency of Metabolic Syndrome. There was no association between the syndrome and its components with anti-TNF therapy; BASDAI; BASFI; metric evaluation; uveitis; degree of sacroiliitis and syndesmophytosis.

Conclusion: The prevalence of Metabolic Syndrome was below that is described in other populations. The presence of HLA-B27 was considered a protective factor for Metabolic Syndrome, triglyceride levels and fasting glycemia. This finding may be related to the presence of several HLA-B27 alleles, usually non-subtyped, and to the great ethnic miscegenation of the Brazilian population. Our observation suggests that spondylitis should be routinely evaluated for cardiovascular risk factors.

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AB1287

DISEASE EVOLUTION OF PRIMARY SJOGREN'S SYNDROME – A LONGITUDINAL STUDY

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Background: The natural history of primary Sjogren's syndrome (pSS) remains poorly understood. It has been suggested that the initial presentations may predict the course of disease (1), with gradual reduction of biological activity as measured

by serum Immunoglobulins levels (2), while symptoms such as fatigue remaining stable over time(3).

Objectives: To evaluate how pSS progresses over time using ESSDAI (Eular Sjögren's Syndrome Disease Activity Index) and the ESSPRI (Eular Sjögren's Syndrome Patient Index), EQ5D-Time trade off (TTO) and Visual Analogue Scale (VAS) of health states.

Methods: Routine clinical data from a large single centre cohort in the UK were analysed on patients with ≥ 3 clinical visits, including up to the 10th visit. Outcomes (ESSDAI/ESSPRI and their component scores, EQ5D-3L and VAS) were analyzed by a random effects linear regression using STATA 14.

Results: 346 patients out of 858 included, with a female preponderance of 89%, and median age of 63 years. The median follow up time was 4.9 years, and median disease duration of 12 years. Anti-Ro was positive in 61% and anti-La in 42% of the patients.

ESSDAI score decreased 0.1 point per visit ($p=0.006$). Anti-Ro and anti-La positive patients exhibiting a lower score ($p=0.012$ and 0.031), and patients with MALT at presentation had a score up to 6 points higher ($p=0.002$). Regarding the ESSDAI domains, the constitutional and haematological domains showed increased activity ($p\text{-value}<0.0001$ and 0.018), with Anti-Ro and/or Anti-La patients having higher scores ($p<0.0001$ and 0.001). In contrast, the glandular, articular and peripheral nervous system domains showed decreases over time ($p\text{-values } 0.003, 0.006$ and <0.0001).

ESSPRI score increased 0.05 point/visit ($p<0.0001$). While Dryness scores remained relatively constant, Pain and Fatigue components of the ESSPRI increased over time (both $p<0.0001$). Dryness scores were higher in female patients ($p=0.04$).

EQ5D-TTO worsened by 0.03 point/visit ($p<0.0001$), but the VAS health states remained stable.

Conclusion: Our data suggest that symptoms of fatigue and pain as well as health utility worsen over time, whereas different ESSDAI domains showed different trends over time. Longer term follow-up to further understand the natural history of pSS is warranted.

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AB1288

PREVENTION OF VENOUS THROMBOEMBOLISM AND THE RISK OF POSTOPERATIVE COMPLICATIONS IN PATIENTS WITH RHEUMATOID ARTHRITIS AFTER TOTAL HIP ARTHROPLASTY:

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Background: According to the administrative data, confirmed by several meta-analyses, patients with rheumatoid arthritis (RA) in comparison with the General population shows an increased risk of venous thromboembolic complications more than twice. Drug prevention can reduce the risk of venous thromboembolism (VTE) in patients with rheumatic diseases.

Objectives: The aim of this study was to analyze frequency of VTE, risk of bleeding and complications of the postoperative wound in patients with RA and osteoarthritis (OA) after total hip arthroplasty (THA).

Methods: Study included 486 patients (212 - with RA and 274 - with OA) who underwent primary THA. Each group of patients was divided into 3 subgroups by type of drug therapy (1-nadroparin calcium; 2-dabigatran etexilate; 3-nadroparin calcium with transfer to dabigatran etexilate). Intra- and postoperative blood loss and the wound healing process were assessed during the first 7 days after surgery.

Results: Postoperative VTE were reported in 36 (7.4%) of 486 patients. VTE in patients with RA were detected significantly less frequently than in OA (1.2% and 6.1%, $p = 0.0013$). Bleeding that required transfusion

of blood in RA were found significantly more often than in OA (respectively 14.4% and 5.7% of cases; $P<0.001$). The number of cases requiring cancellation of anticoagulant therapy in patients with RA was significantly higher compared with the OA group (6.6% and 1.4%, respectively). Slow wound healing in RA was more common ($n = 56$; 26.4%) than in OA ($n = 14$; 5.1%). In patients who underwent monotherapy with calcium nadroparin VTE occurred more often than when using combination therapy ($p<0.0001$) and more often than in the group of dabigatran etexilate ($p=0.054$).

Conclusion: The frequency of VTE, the risk of bleeding and complications of postoperative wound in patients with RA and OA after THA were analyzed. So, our study determined the dependence of VTE complications and bleeding risk according to the patient's underlying nosology. Also the advantage of combined postoperative therapy over others was evaluated.

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AB1289

TESTING DIFFERENT ITEMS INCLUDED IN THE DEFINITION OF REMISSION IN A MULTICENTRE SLE COHORT

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Background: Remission is the most desirable target in the treatment systemic lupus erythematosus (SLE) however, a universally accepted definition of remission in SLE is still missing.

Objectives: To test the contribution of the different items included into the currently used definitions of remission in SLE.

Methods: We studied 646 Caucasian patients from a multicentre lupus cohort followed for at least 5-years: female 585 (90.6%), mean age at baseline 40.59±12.14 years, mean disease duration 9.18±6.86 years. Disease activity was assessed by clinical SLE Disease Activity Index 2000 (cSLEDAI) and SELENA-SLEDAI physician global assessment (PGA), and damage by Systemic Lupus International Collaborating Clinics/ACR Damage Index (SDI). To test the performance of the different items included in the definitions of SLE remission [1, 2] we identify 7 subtypes of remission: (1) PGA (0-3)<0.5; (2) cSLEDAI=0; (3) prednisone (PDN)≤5mg/day; (4) PGA<0.5 and PDN≤5mg/day; (5) cSLEDAI=0 and PGA<0.5; (6) cSLEDAI=0 and PDN≤5mg/day; (7) cSLEDAI=0 and PDN≤5mg/day and PGA<0.5. The effect of remission on SDI was evaluated by Poisson regression analysis.

Results: The number of patients achieving remission according to the different definitions is show in Figure 1. The proportion of patients who maintained prolonged remission (5-consecutive years) was: PGA<0.5 13.0%; cSLEDAI=0 18.4%; PDN≤5mg/day 34.4%; PGA<0.5 and PDN≤5mg/day 12.5%; cSLEDAI=0 and PGA<0.5 12.7%; cSLEDAI=0 and PDN≤5mg/day 16.6%; cSLEDAI=0 and PDN≤5mg/day and PGA<0.5 12.4%.

Figure 1. Number of patients in remission according to the 3 single items (prednisone≤5 mg/day; PGA<0.5; cSLEDAI=0) and their overlap during a follow-up period of 5 years for all the patients. **A)** Patients achieving at least 1-year remission. **B)** Patients achieving prolonged remission (5-consecutive years).

Figure 1

Table 1. Performance of 7 different remission subtypes in defining the risk of damage accrual (upper part) and the goodness-of-fit of the model (lower part).

	cSLEDAI=0	PGA<0.5	PDN ≤5mg/day	PGA<0.5 and PDN ≤5mg/day	cSLEDAI=0 and PGA<0.5	cSLEDAI=0 and PDN ≤5mg/day	cSLEDAI=0 and PDN ≤5mg/day and PGA<0.5
	OR (CI95%) ^a						
1-year remission pts vs unremitted	0.766 (0.548-1.072)	0.808 (0.590-1.108)	0.952 (0.610-1.485)	0.764 (0.554-1.054)	0.857 (0.629-1.167)	0.894 (0.646-1.236)	0.800 (0.583-1.098)
2-year remission pts vs unremitted	0.454 (0.318-0.647)	0.560 (0.395-0.794)	0.858 (0.566-1.301)	0.495 (0.341-0.718)	0.514 (0.359-0.737)	0.501 (0.347-0.722)	0.479 (0.327-0.702)
3-year remission pts vs unremitted	0.512 (0.342-0.768)	0.427 (0.280-0.650)	0.912 (0.600-1.387)	0.430 (0.278-0.665)	0.459 (0.3015-0.698)	0.559 (0.370-0.845)	0.438 (0.283-0.677)
4-year remission pts vs unremitted	0.173 (0.105-0.286)	0.226 (0.130-0.395)	0.391 (0.245-0.626)	0.294 (0.177-0.488)	0.243 (0.140-0.425)	0.253 (0.156-0.408)	0.296 (0.176-0.497)
5-year remission pts vs unremitted	0.382 (0.260-0.561)	0.377 (0.238-0.595)	0.620 (0.430-0.895)	0.363 (0.226-0.581)	0.397 (0.251-0.628)	0.413 (0.276-0.618)	0.374 (0.234-0.560)
	Goodness-of-fit of the model						
AIC	1082.90	1100.62	1132.83	1105.87	1103.96	1101.13	1106.59
BIC	1109.72	1127.44	1159.66	1132.70	1130.78	1127.96	1133.42
p Value	<0.0001	<0.0001	0.0003	<0.0001	<0.0001	<0.0001	<0.0001

pts: patients; PDN: prednisone; OR: Odds ratio; CI: confidence interval.

^aSignificative values are given in bold ($p<0.001$).

Figure 1

When PGA<0.5 was added to cSLEDAI, 198 (30.7%) patients lost 353 years in remission (1.8 years/patient): among them 195 (98.5%) showed a $0.5\leq PGA\leq 1$ suggesting a low disease activity state (LDA). When, PGA<0.5 was added to cSLEDAI =0 and PDN ≤5mg/day, 151 (23.5%) patients lost 254 years in remission (1.7 years/patient): among them 149 (98.0%) showed a $0.5\leq PGA\leq 1$ suggesting again LDA. All remission subtypes were protective against damage ($p<0.001$), however cSLEDAI=0 showed the best performance (lower AIC) (Table 1). At multivariate analysis all remission subtypes lasting ≥2 consecutive years were protective against damage ($p<0.001$), except PDN≤5mg/day which was protective after 4 consecutive years.

Conclusion: The prevalence and extent of damage significantly decreased as the time spent in remission increased, irrespective of the remission subtype. The addition of PGA<0.5 to cSLEDAI=0 or to cSLEDAI=0 and PDN≤5mg/day results in a decrease in the time spent in remission without significant difference in damage accrual.

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AB1290

VITAMIN D AND PAIN SYNDROME IN BREAST CANCER PATIENTS TREATED WITH ADJUVANT LETROZOLE

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Background: The third-generation aromatase inhibitors (AIs) have shown a favorable overall risk-benefit profile in the upfront adjuvant therapy of postmenopausal estrogen receptor-positive breast cancer. Breast cancer patients treated with long term AIs experience arthralgias and musculoskeletal aching often described as bone pain, musculoskeletal disorder, arthralgia.

Objectives: The purpose of this study was to investigate clinical, serological and anamnestic features associated to the joint pain syndrome in non-metastatic breast cancer patients treated with adjuvant AIs.

Methods: Between June 2017 and December 2017 patients with early stage estrogen receptor-positive breast carcinomas treated with adjuvant letrozole, attending our Rheumatologic clinic to undergo osteoporosis screening, were included. Pre-existing symptoms and clinical, serological and imaging features were evaluated to assess the type of musculoskeletal disorder.