tendinitis, pain in joint; analgesia, gastric protector and NSAIDs; hypertension, dyslipidemia and diabetes respectively. The predictors with a greater negative impact in HRQoL were the use of 3rd level analgesics and azathioprine, a presence of kidney failure, fibromyalgia, and ischemic heart disease. Conversely, use of symptomatic slow action drugs for osteoarthritis, statins, lowering uric acid drugs, a diagnose of mixed connective tissue disease, and better HRQoL in the past six months were independently associated with a positive impact in the HRQoL.

Conclusion: We have identified several diagnoses, treatments and comorbidities independently associated with HRQoL in a cohort of patients followed up in a rheumatology outpatient clinic. This represent a first step in the implementation of value-based care for MSK patients, as we can now review the procedures associated with a worse HRQoL in an attempt to improve them.

References:

Predictor selection. Dx: Diagnoses. DxE: Diagnoses Episode. DxTFT: Diagnoses Total Follow-up Time.

DxTET: Diagnoses Total Episode Follow-up Time T: Treatment. DxE: Treatment Episode. DxTFT:

Treatment Total Follow-up Time. DxTET: Treatment Total Episode Follow-up Time. XM: Comorbidities

and Concomitant Treatments. DM: Demographics. HS: Health Status.

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SAT0599 FEET DERMATOLOGICAL CONDITIONS AND DEFORMITIES IN RHEUMATOID ARTHRITIS

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Background: It has been extensively studied the repercussions of rheumatoid arthritis (RA) in hands and in their function. However, the evidence regarding the effect on feet and dermatological problems is scarce¹.

Objectives: Describe risk factors associated with foot deformities (FD) in patients with RA.

Methods: This was a descriptive and observational cross-sectional study. Patients were consecutively recruited. Demographic-clinical data was registered and through physical examination the presence of FD, dermatological problems and pain location were assessed. The Foot Function Index (FFI) survey was used to measure foot functioning. Functional capacity was evaluated using the Health Assessment Questionnaire (HAQ) tool and quality of life with the Rheumatoid Arthritis Impact Disease (RAID) questionnaire. The risk of falling was calculated with Tinetti's scale. An adjusted binary logistic regression was performed to compare patients with and without foot deformities. Models were adjusted for FFI's, HAQ's, RAID's and Tinetti's scores.

Results: We included 76 subjects with RA with a mean age of 52.6 (11.40) years old. The 68.4% presented FD, while 69.7% had dermatological problems. Patients with FD were older ($p=.005$), had a more affected function of their feet ($p=.002$), greater risk of falling ($p=.002$) and worst functional capacity ($p=.007$) and quality of life ($p=.026$). Some factors that increased the risk of having FD in patients with RA were: age (OR 1.07, 95%CI: 1.001-1.147; $p=.048$), pain in toes and in the forefoot (OR 6.194; 95%CI: 1.172 – 32.743; $p=.032$) and having dermatological conditions in feet (OR 0.244; 95%CI: 0.067 – 0.881; $p=.031$).

Conclusion: Foot deformities and dermatological problems were present in more than the half of our sample. Older patients and subjects with dermatological problems and pain in toes and forefoot had a greater risk of presenting foot deformities.

References:

- [1] A. Göksel Karatepe, et al. "Foot deformities in patients with rheumatoid arthritis: The relationship with foot functions," *Int. J. Rheum. Dis.*, vol. 13, no. 2, pp. 158–163, 2010.

Table 1. Demographic characteristics (n=76)

Age, mean (SD)	52.605 +/- 11.40
Women, n (%)	76 (96.1)
BMI*, median (IQR)	27.54 (24.00-30.38)
Disease duration**, median (IQR)	96.00 (24.00 – 210.00)

Table 1. Demographic characteristics (n=76)

Diabetes mellitus, n (%)	19 (25.0)
Arterial hypertension, n (%)	21 (27.6)
DAS28-PCR, mean (SD)	2.99 (1.61)
HAQ-score, median (IQR)	0.81 (0.25 – 1.47)
RAID-score, median (IQR)	4.74 (3.06 – 7.52)
FFI-score, mean (SD)	45.99 (27.37)
Tinetti-score, median (IQR)	22.50 (10.00 – 45.50)
Feet deformities, n (%)	52 (68.4)
Hallux valgus, n (%)	38 (50)
Claw toe, n (%)	23 (30.3)
Hammer toe, n (%)	9 (11.8)
Overlapping toes, n (%)	14 (18.4)
Dermatological problems	53 (69.7)
Ulcerations	1 (1.3)
Plantar hyperkeratosis	30 (39.5)
Plantar corn	6 (7.9)
Onychomycosis	24 (31.6)
Onychocryptosis	5 (6.6)
Subungual hematoma	1 (1.3)

* kg/m² ** months

Table 2. Comparison between presence and absence of foot deformities.

	Present n=52	Absent n=24	p
Age, mean (SD)	54.88 (11.63)	47.66 (9.31)	.005
Disease duration*, median (IQR)	120 (28.5-246)	54 (12-138)	NS
BMI**, median (IQR)	27.00 (23.95 – 30.40)	28.20 (25.01 – 31.68)	NS
DAS 28, mean (SD)	3.08 (1.61)	2.80 (1.64)	NS
FFI, mean (SD)	52.32 (24.78)	32.26 (28.18)	.002
Tinetti's scale, median (IQR)	37.50 (10.75 – 63.00)	12.00 (10 – 21.750)	.002
HAQ, median (IQR)	1.19 (0.37 – 1.78)	0.565 (0.00 – 0.910)	.007
RAID, median (IQR)	5.75 (3.46 – 7.52)	3.51 (1.27 – 6.81)	.026
Pain location, n (%)			.027
Absent	7 (13.46)	7 (29.16)	NS
Toes and forefoot	36 (69.23)	8 (33.33)	NS
Midfoot	2 (3.84)	1 (4.16)	NS
Rearfoot	7 (13.46)	8 (33.33)	NS
Pain intensity, mean (SD)	6.308 (3.01)	4.54 (3.50)	.027
Dermatological problems, n (%)	42 (80.76)	13 (54.16)	.003

*months ** kg/m². NS: not significative.

Disclosure of Interests: None declared

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SAT0600 PNEUMOCOCCAL VACCINATION IN PATIENTS WITH AUTOIMMUNE INFLAMMATORY RHEUMATIC DISEASES, TREATED WITH BIOLOGICAL THERAPY AND WITH A LOW LEVEL OF ANTIBODIES - A COHORT STUDY OF PATIENTS WITH VARYING VACCINATION STATUS.

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Background: Risk of infection is increased in patients with autoimmune inflammatory rheumatic diseases (AIRD)¹. Furthermore, disease-modifying antirheumatic drug (DMARD) treatment contributes to this risk². To reduce the risk of serious infections, it is recommended that patients are vaccinated against *Streptococcus pneumoniae*³. However, some AIRD patients do not develop or maintain an adequate antibody response after pneumococcal vaccination⁴.

Objectives: The aim of the study was to examine the proportion of patients with low antibody levels, who achieved a protective level of pneumococcal antibodies after vaccination.

Methods: Pneumococcal antibodies were measured by a serological assay in patients treated with biologics in a rheumatology outpatient clinic. Vaccination with 23-valent-pneumococcal polysaccharide vaccine was then offered to patients with a protective antibody level below the defined threshold and pneumococcal antibody level was measured at follow-up 2-3 months later. The patients continued their DMARD treatment without any changes.