$p=0.41$). In the overall population, the baseline presence of at least one EAM was associated with a more frequent prescription of anti-TNF monoclonal antibodies rather than etanercept (14.4% versus 6.7%, respectively; $p=0.004$). Moreover, we observed a numerically, although not statistically significant, higher proportion of EAMs in patients treated with anti-TNF monoclonal antibodies rather than secukinumab (6.5%), ustekinumab (7.1%), and apremilast (5.9%).

Conclusion: In our real-life cohort of SpA patients treated with targeted therapies, EAMs were highly represented at baseline, especially uveitis in axSpA and IBD in peripheral SpA. The presence of extra-articular involvement was associated with a preferential prescription of anti-TNF monoclonal antibodies rather than etanercept or drugs with different mechanisms of action.

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AB0672

PATIENT CHARACTERISTICS AND DISEASE ACTIVITY, BUT NOT THE CRANIOCERVICAL POSTURE ABNORMALITIES PREDICT TEMPOROMANDIBULAR DISORDERS IN ANKYLOSING SPONDYLITIS PATIENTS: A CROSS-SECTIONAL, OBSERVATIONAL STUDY

E. Bilgin¹, E. Bilgin², O. Özdemir³, U. Kalyoncu². ¹Gaziler Fizik Ted. ve Reh. Eğt. Arş.Hastanesi, Ankara, Turkey; ²Hacettepe Üniversitesi Tıp Fakültesi, Internal Medicine, Division of Rheumatology, Ankara, Turkey; ³Hacettepe Üniversitesi Tıp Fakültesi, Physical Medicine and Rehabilitation, Ankara, Turkey

Background: There are contradictory results in the relevant literature about the relationship between objective determinants of craniocervical posture and temporomandibular disorder (TMD), whereas no study has worked on AS and TMD relationship.

Objectives: To evaluate the predictors of TMD in AS patients and its relationship with craniocervical posture, we conducted this study

Methods: AS patients aged between 18-50 years and consecutively admitted to our outpatient clinics were recruited. TMD was diagnosed by 'Diagnostic Criteria for Temporomandibular Disorders (DC/TMD)' criteria. Spinal mobility was assessed by BASMI; disease activity by ASDAS-CRP and neck disability by Neck Disability Index. We measured the craniocervical angle, cervical curvature angle, suboccipital distance, atlas-axis distance, anterior translation distance by using the lateral cervical X-rays (Figure).

Results: A total of 98 (58.2% female) patients with a mean age of 37.4 ± 48.2 years was recruited (Table 1). TMD was diagnosed in 58 (59.2%) patients. Spinal mobility and craniocervical posture measurements were similar among the two groups (Table 2). Smoking, bruxism (in females), neck disability and AS activity (in males) were higher in TMD patients (Table 1). Multivariate analysis revealed active smoking (aOR 6.86; CI: 1.83-25.60; $p=0.004$), bruxism in females (aOR 17.87; CI: 2.0-159.20; $p=0.01$), high ASDAS in males (aOR 11.82; CI: 1.14-122.5; $p=0.038$) and neck disability (aOR 12.67; CI: 3.75-42.85; $p<0.001$) as independent risk factors for TMD in AS patients.

Conclusion: No relationship between the craniocervical posture measurements and TMD was found in AS patients. Active smoking, high disease activity in males, bruxism in females and neck disability were found as predictors of TMD in AS patients.

Table 1. The clinical and demographical data of the study population

Parameter	All patients	TMD (+) (n=58)	TMD (-) (n=40)	P value
Gender (Female)	57 (58.2)	38 (65.5)	19 (47.5)	0.076
Age	37.4±8.2	37.8±7.7	36.9±8.9	0.57
Smoking				
Smoker	33 (33.7)	25 (43.1)	8 (20.0)	0.017
Non-smoker	65 (66.3)	33 (56.9)	32 (80.0)	
AS disease duration (year)	8.1±5.7	7.8±6.2	8.6±5.0	0.47
AS treatment				
NSAID				0.52
Regular	13 (13.2)	8 (13.8)	5 (12.5)	
On-demand	49 (50.0)	31 (53.4)	18 (45.0)	
Sulphasalazine	38 (38.7)	24 (41.4)	14 (35.0)	0.67
Anti-TNF agents	59 (60.0)	33 (56.9)	26 (65.0)	0.42
Bruxism				
Present	61 (62.2)	43 (74.1)	18 (45.0)	0.003
Nighttime	18 (29.5)	11 (25.6)	7 (38.9)	
Daytime	15 (24.6)	10 (23.3)	5 (27.8)	
Whole day	28 (45.9)	22 (51.2)	6 (33.3)	
Absent	37 (37.8)	15 (25.9)	22 (55.0)	

Table 2. Comparison of AS-related and craniocervical posture measurements

Parameter	All patients	TMD (+) (n=58)	TMD (-) (n=40)	P value
AS-related measurements				
ASDAS	2.4±0.95	2.7±0.93	2.0±0.85	0.001
Male	2.3±1.3	2.7±1.14	1.7±0.85	0.007
Female	2.5±0.9	2.7±0.82	2.4±0.78	0.11
Tragus-wall distance (cm)	11.7±2.55	11.6±1.97	12.0±3.24	0.41
Cervical rotation (angle)	71.6±12.78	71.6±12.32	71.5±13.59	0.94
Chin-thorax distance (cm)	2.1±1.64	2.1±1.44	2.1±1.91	0.90
BASMI	2.0±1.19	2.0±1.11	2.1±1.31	0.76
mSASSS	3.5±4.84	3.4±3.88	3.8±6.03	0.70
Measurements of craniocervical posture				
Craniocervical angle	79.6±10.31	78.9±10.47	80.6±10.11	0.41
Cervical curvature angle	165.4±12.42	165.6±12.89	165.0±11.84	0.82
Suboccipital distance (mm)	6.3±3.97	6.2±4.04	6.5±3.91	0.71
Atlas-axis distance (mm)	5.2±2.43	5.3±2.47	5.0±2.40	0.62
Anterior translation distance (mm)	10.9±13.74	11.4±11.79	10.1±16.35	0.66

Figure. For the assessment of craniocervical posture; suboccipital distance (A.a.), atlanto-axial distance (A.b.) anterior translation distance (A.c), craniocervical angle (B.a), cervical curvature angle (B.b) were measured on standardized lateral X-rays.

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AB0673

SHINING LIGHT ON AXIAL SPONDYLOARTHRITIS: DISEASE ACTIVITY AND VITAMIN D. WHAT'S THE LINK?

G. A. Brown¹, K. M. Torsney², E. Nikiphorou³. ¹North West Anglia NHS Foundation Trust, Peterborough City Hospital, Rheumatology, Peterborough,