reported. In 31 (12.5%) of the publications the causative agent for the ReA was unknown, the diagnosis was made clinically.

Conclusion: In this study, it is aimed to draw attention terminology intricacy and the need for the standardization of the definition of ReA and USpA. It is clear that to standardize the definition of Rea and USpA is necessary. Between 2009-2019 there are reported cases diagnosed as ReA associated with bacterial infections (especially with *Clostridium difficile*, streptococcus and tuberculosis infections), and viral infections (by a majority with HIV), and parasitic infections. It is not clear if we need to define them classically or define them as USpA. Another important consideration is the necessity of extended laboratory investigations to find out the real causative agent even if the patient is clinically diagnosed with ReA. The requirement of the differentiation between ReA and USpA must be revealed for therapeutic researches.

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AB0678

RISK FACTORS FOR ADVERSE PREGNANCY OUTCOMES IN SPONDYLOARTHRITIS: DISEASE PHENOTYPE AND DISEASE ACTIVITY MAY PLAY A ROLE

A. R. Cruz-Machado¹, F. Crisafulli², M. C. Gerardi², M. Filippini², M. Fredi², R. Gorla², M. G. Lazzaroni², C. Nali², M. Taglietti², A. Lojaco³, C. Zinardini³, S. Zatti³, L. Andreoli², F. Franceschini², A. Tincani². ¹Hospital de Santa Maria, Serviço de Reumatologia e Doenças Ósseas Metabólicas, Lisboa, Portugal; ²Spedali Civili Di Brescia, Rheumatology and Clinical Immunology, Brescia, Italy; ³Spedali Civili Di Brescia, Obstetrics and Gynaecology, Brescia, Italy

Background: Pregnant patients (pts) with spondyloarthritis (SpA) seem at increased risk for adverse pregnancy outcomes (APO), however limited and conflicting data have been published so far and risk factors for APO in these pts remain poorly understood.

Objectives: To assess APO and identify possible risk factors for those in a cohort of SpA pregnant pts.

Methods: Data on SpA pts prospectively-followed in a pregnancy clinic from 2010 to 2019 were retrospectively analysed before conception and during each trimester. Pregnancies complicated by APO were compared with those that were uneventful for demographic and clinical variables. Active disease was defined as a DAS-28-CRP > 3.2 or an ASDAS-CRP ≥ 2.1 according to peripheral or axial dominant disease respectively.

Results: 56 pregnancies (mean age 34±5 years; median disease duration 60 months, IQR 24-123) in 47 pts were analysed: 37 psoriatic arthritis, 7 axial SpA, 6 undifferentiated SpA, 3 enteropathic SpA, 2 reactive arthritis and 1 enthesitis-related juvenile idiopathic arthritis. APO were recorded in 23/56 (41%) pregnancies: 5 (9%) early miscarriages, 1 (2%) medical abortion (central nervous system malformation), 3 (5%) preterm births (≥34 gestational week, all for preterm premature rupture of membranes - PROM); 2 (4%) PROM; 7 (13%) small for gestational age newborns (SGA); 3 gestational diabetes and 2 cholestasis of pregnancy. Table 1 displays the comparison between pregnancies with and without APO. A higher number of pts with active disease were detected during the 2nd trimester in both groups, however differences between those were only significant at the 3rd trimester (p=0.03). History of inflammatory bowel symptoms (IBS) was also associated with an increased risk for APO (p=0.02). Although not reaching statistical significance, APO occurred more frequently in pts with a previous use of > 1 conventional synthetic (cs) or biological (b) disease-modifying antirheumatic drug (DMARD) (p=0.05), suggesting a more difficult to treat phenotype. Likewise, pts with APO were less often treated with low dose aspirin (LDA) during pregnancy.

Conclusion: SGA was the main APO recorded. History of IBS, a more difficult to treat phenotype and the presence of active disease during pregnancy influenced APO in this cohort, reinforcing the need for tight disease control before and during pregnancy. Larger and prospective data are warranted to confirm these results and to assess the potential protective role of LDA.

References:

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Table 1. Differences between patients with and without APO

	Pregnancies with APO	Pregnancies without APO	p
N, %	23, 41.1	33, 58.9	
Maternal age at conception, mean±SD (years)	33.8±5	33.8±4.9	NS
Hx previous APO – N, %	4, 17.4	3, 9.1	NS
Disease duration, median (IQR), (months)	96 (36-132)	48 (24-96)	NS
Axial dominant disease – N, %	6, 26.1	6, 18.2	NS
Peripheral dominant disease – N, %	11, 47.8	20, 60.6	NS
Hx enthesitis – N, %	9, 39.1	13, 39.4	NS
Hx dactylitis – N, %	5, 21.7	11, 33.3	NS
Hx psoriasis – N, %	10, 43.5	18, 54.5	NS
Hx uveitis – N, %	1, 4.3	4, 12.1	NS
Hx inflammatory bowel symptoms – N, %	4, 17.4	0, 0	0.02
HLA-B27 – N, %	8, 34.8	7, 21.2	NS
>1 cs or bDMARDs before conception – N, %	13, 56.5	10, 30.3	0.05
LDA during pregnancy – N, %	7, 30.4	17, 51.5	NS
Active disease before conception – N, %	5, 21.7	2, 6.1	NS
Active disease 1 st trimester – N, %	1, 4.3	4, 12.1	NS
Active disease 2 nd trimester – N, %	6, 26.1	5, 15.2	NS
Active disease 3 rd trimester – N, %	3, 13	0, 0	0.03

Legend: Hx – history of; NS – non significant.

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AB0679

HEALTH ASSESSMENT IN FEMALE PATIENTS WITH SPONDYLOARTHRITIS: FOCUS ON REPRODUCTIVE SPHERE

E. De Martino¹, P. Conigliaro¹, M. S. Chimentì¹, P. Triggianese¹, S. L. Bosello², E. Gremese², C. Iannuccelli³, F. R. Spinelli³, M. Vadacca⁴, R. Perricone¹.

¹University of Rome "Tor Vergata", Rome, Italy; ²Catholic University of Sacred Heart of Rome A. Gemelli, Rome, Italy; ³University of Rome, La Sapienza, Rome, Italy; ⁴University of Rome Campus Bio Medico, Rome, Italy

Background: SpA patients experience a decreased quality of life due to social, emotional and relational life impairment in addition to pain, fatigue and joint damage. Sexual dysfunction (SD) is often neglected by both patients and clinicians, although articular and extra-articular manifestations of the disease can decrease the quality of sexual life. Previous findings showed that SD can affect from 27% to 67% of patients with rheumatic diseases. Data available on SD in rheumatic patients are poor and primarily focus on male ankylosing spondylitis patients.

Objectives: The aim of this study is to evaluate, in a group of female SpA patients, the presence of SD, its relationship with extra-articular manifestations and to estimate the correlation between disease activity and sexual activity.

Methods: 52 SpA patients (including PsA, IBD-SpA and undifferentiated SpA-un-SpA) and 50 healthy controls (HC) were administered the Female Sexual Function Index (FSFI) questionnaire for the analysis of sexual function (score from 0 to 100). SD is defined by a score lower than 26. Disease activity was evaluated through DAPSA and BASDAI. SpA-HAQ and BASFI was also performed to assess functional status.

Results: There was a trend for a significantly greater proportion of SD in the patients (21%) than the controls (8%), $\chi^2(1, N = 102) = 3.52, p = .06$. Within the different groups, the percentage of those with SD according to the FSFI cut off were 23% of PsA patients, 25% of IBD-SpA patients, 11% of un-SpA patients, and 8% of healthy controls, however, when the patient groups were analysed separately these differences were not significant, $\chi^2(3, N = 102) = 4.43, p = .22$. Mean scores on the FSFI were lower for the total SpA patients group $t(100) = 2.47, p = .02$ compared to HC. When scores on the FSFI were analysed separately for each patient group, there was a trend for a significant difference between the groups, $F(3,98) = 2.43, p = .07$, and follow up t-tests showed that only the PsA group scored significantly lower than the HC, $t(100) = 2.56, p = .01$ (see Fig. 1). Among the items of the questionnaire, questions regarding sexual desire, lubrication and discomfort were statistically significantly lower scores in patients compared to HC ($p = 0.001, p = 0.009, p = 0.02$, respectively). For the overall patient group, the FSFI was significantly negatively correlated with the DAPSA ($r = -.37, p = .008$), the SpA-HAQ ($r = -.30, p = .03$) and the BASFI ($r = -.30, p = .03$). Additionally, the PsA group showed a negative correlation between DAPSA scores and FSFI score ($r = -.38, p = .03$) and the IBD-SpA group had a negative correlation between FSFI score and BASFI ($r = -.80, p = .002$).

Conclusion: Overall, the data generally show that SD is more common in SpA patients compared to HC and that SpA patients score lower on the FSFI. The negative correlations between the FSFI and scores on DAPSA, SpA-HAQ and BASFI suggest that sexual function may be poorer for patients with greater disease activity and poorer functional status. These findings could be due to the number of tender and/or swollen joints as well as chronic pain or fatigue patients