Results: A German cohort of 150 AxSpA patients with 89 male and 61 female patients (mean age 49.3 years for males, 48.5 for females, $p=0.77$) was analyzed for functional capacity. Female patients had a significantly higher functional impairment in everyday life compared to males ($p=0.013$). After adjusting for age, linear regression showed female sex still to be significantly associated with functional impairment. Female patients rated their satisfaction with health as well as their physical and mental health-related quality of life significantly lower than male patients ($p=0.015$, respectively $p=0.003$ and $p=0.002$).

There were no significant differences in disease duration, diagnostic delay or family history between male and female patients ($p=0.731$, $p=0.971$ and $p=0.776$). Women had a slightly higher disease activity (BASDAI 4.08 vs. 3.36), although just not statistically significant in our cohort ($p=0.056$). Female patients had more peripheral joint involvement (52.5% vs. 34.8%, $p=0.032$), as well as more enthesitis (31.1% vs. 16.9%, $p=0.04$), whereas there were no differences concerning eye involvement ($p=0.51$). Female patients were less likely to be HLA B27 positive (65.6 vs. 80.7%, $p=0.04$), and were less likely to be on anti-TNF treatment ($p=0.032$, respectively $p=0.042$).

Conclusion: Also in our cohort female patients had a higher burden of disease as well as a worse patient reported outcome with worse quality of life and more self-reported functional impairment in everyday life. These data underline the importance of raising awareness for sex differences in disease presentation and suggest that female patients might require different treatment to achieve improved outcomes.

Disclosure of Interests: None declared

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IS THE NEW ASDAS NOMENCLATURE IN LINE WITH THERAPEUTIC DECISION MAKING IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS?

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Background: The Assessment of SpondyloArthritis international Society (ASAS) proposed in 2018 a change in the nomenclature of the Ankylosing Spondylitis Disease Activity Score (ASDAS) for monitoring disease activity in axial spondyloarthritis (axSpA), renaming the previously status of moderate disease activity as low disease activity status, with the presumption that this better reflects the perception that the doctor and the patient have about the disease situation. However, this decision was not data-driven.

Objectives: To evaluate the association between the state of low disease activity according to the new ASDAS nomenclature and the therapeutic decision in patients with axSpA.

Methods: Longitudinal retrospective study in which patients with axSpA recruited in a secondary hospital were included. All patients with clinical diagnosis of axSpA who started treatment with a first inhibitor of tumor necrosis factor between January 2014 and June 2019 were included. At each follow-up visit, disease activity assessments (including BASDAI and CRP) and the therapeutic decision of the doctor were collected. Later, the ASDAS was calculated and disease status at each visit was classified according to the new nomenclature (inactive, low, high and very high activity). Using descriptive statistics, the association between the disease activity status and the therapeutic decision was evaluated.

Results: A total of 304 visits were analyzed in 104 patients with axSpA. Out of these, 57% were women, 47% had a subtype of non-radiographic axSpA and 42% were HLA-B27 positive. The mean (standard deviation) age at diagnosis was 46.9 (12.5) years. In the visits with an ASDAS showing a status of low activity, the therapeutic attitude was not to intensify the treatment in 98.2% of the cases. However, in visits with an ASDAS status of high or very high disease activity, treatment was intensified in 33.7% and 82.8% of cases, respectively.

Conclusion: In clinical practice, the status of disease activity initially classified by the ASDAS as moderate disease activity is currently considered to represent low disease activity status based on the therapeutic attitude of following a non-intensification strategy in this situation. These data support the recent change in the nomenclature of disease activity states according to the ASDAS.

References:

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Figure 1. Association between the state of disease activity according to the new ASDAS nomenclature and the therapeutic decision.

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COMPARATIVE ANALYSIS OF PATIENT-REPORTED OUTCOMES AMONG EMPLOYED AND UNEMPLOYED PATIENTS WITH AXIAL SPONDYLOARTHRITIS. RESULTS OF THE SPANISH ATLAS 2017

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Background: Unemployment is associated with poorer disease outcomes in chronic conditions. Current high rates of unemployment in Spain may lead to a higher burden of disease in axial spondyloarthritis (axSpA) patients.

Objectives: To evaluate the differences in sociodemographic factors and patient-reported outcomes (PROs) between employed and unemployed axSpA patients in the same sample.

Methods: Data from 680 unselected patients of the Spanish Atlas of Axial Spondyloarthritis from an online survey were collected in 2016 were analysed. Active workforce participants were divided into employed and unemployed according to International Labour Organization (ILO) standards. Socio-demographic characteristics, and Patient-reported Outcomes (PROs) [BASDAI (0-10), spinal stiffness (3-12), functional limitation (0-54) and psychological distress (0-12, General Health Questionnaire GHQ-12)] were compared between employed and unemployed participants. The χ^2 test was used for qualitative variables and the Mann-Whitney test for quantitative variables.

Results: In total, 415 (63.6%) patients were categorised in the active population, of which 325 (78.3%) were employed and 90 (21.6%) unemployed (Table 1). 62.8% (N = 86) of unemployed patients declared that axSpA was the cause of their joblessness. Compared to the unemployed, the employed patients had a higher percentage of university studies (47.1% vs 23.3%; $p=0.001$) and higher income level per family member (€890.4 vs €358.5; $p<0.001$). In relation to PROs, the unemployed presented greater disease activity (6.3 ± 1.9 vs 5.2 ± 1.9 ; $p<0.001$) and spinal stiffness (7.8 ± 2.3 vs 6.5 ± 2.6), worst functional limitation (45.0 ± 8.4 vs 40.6 ± 10.1 ; $p<0.001$) and more psychological distress (7.6 ± 4.2 vs 4.9 ± 4.3 ; $p<0.001$). In addition, a higher proportion of unemployed participants self-reported anxiety (27.8% vs 16.0%; $p=0.011$) and depression (23.3% vs 10.2%; $p=0.001$) (Table 2).