Background: Patients with spondyloarthritis (SpA) suffer not only from pain or physical disability, but they are also affected in multiple facets of life due to this condition (disease impact). Recently, the ASAS group has proposed a new way of capturing the impact that SpA have on patients’ lives, based on the principles proposed by the International Classification of Functioning, Disability and Health (ICF). The tool obtained (ASAS-health index or ASAS-HI) includes 17 items that cover most ICF domains.

Objectives: To analyze the performance of the ASAS-HI in real clinical practice, by comparing it with other standard measures of evaluation of SpA. To assess whether ASAS-HI is able to identify disease activity states in these patients.

Methods: This cross-sectional study included 111 consecutive patients with SpA (ASAS criteria). The correlation (Spearman’s rho) between ASAS-HI, BASDAI, ASDAS, and BASFI was analyzed. ROC curves were constructed to analyze ASAS-HI values that determined BASDAI remission, ASDAS inactive disease, and ASDAS low activity. A logistic regression was made to determine the ASAS-HI items with greater capability to discriminate the state of remission / inactive disease.

Results: Seventy-four men and 37 women were included, mean age of 43.3 ± 10.6 years. The average duration of illness was 7.6 ± 6.8 years. Sixty percent of the series was under biological therapy, HLA-B27 was positive in 79.3%. The average value of ASAS-HI was 5.4 ± 3.8. There were significant correlations between ASAS-HI and BASDAI (rho: 0.89, p < 0.0005), BASDAI and BASFI (rho: 0.86, p < 0.0005), BASFI and ASDAS (rho: 0.78, p < 0.0005), BASDAI and ASAS-HI (rho: 0.77, p < 0.0005), ASDAS and ASAS-HI (rho: 0.70, p < 0.0005). The optimal cut-off point of ASAS-HI for BASDAI remission (Table 1) corresponded to a value ≤ 2. As for the value of ASAS-HI to define ASDAS inactive disease (Table 2), this was ≤ 0. For ASDAS low activity, the value was ≤ 6 (area under the ROC curve 0.82 [95% CI: 0.73-0.90], Sen: 89.5%, Spec: 66.1). In the multivariate regression, the two ASAS-HI items associated with BASDAI non-remission were, “I often get frustrated” [OR 9.2 (95% CI: 1.2-69.4), p = 0.032], and “I sleep badly at night” [OR 7.7 (95% CI: 1.4-41.6), p = 0.018]. As for ASDAS, the only question of ASAS-HI significantly associated with active disease was “pain sometimes disrupts my normal activities” [OR 8.7 (95% CI: 1.7-45.2), p = 0.010].

Conclusion: ASAS-HI correlates well with most outcome measures in SpA. A cut-off point of ASAS-HI ≤ 6 identifies a low disease activity and could be considered a good treatment objective. The evaluation of SpA should include not only conventional measures (BASDAI / ASDAS) but also disease impact measures (ASAS-HI).

References:

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.2351
### Table 1. Comparative characteristics of Group 1 and Group 2 AS patients.

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n=220)</th>
<th>Group 2 (n=9)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, M±SD, y.</td>
<td>40.1±8.6</td>
<td>11.6±1.4</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=35.1±6.9, SD=14.3±7.5</td>
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<tr>
<td>Mean disease duration, M±SD, y.</td>
<td>26.3±6.5</td>
<td>10.1±2.5</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=16.3±6.6, SD=13.4±7.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men, n (%)</td>
<td>162 (73.6%)</td>
<td>4 (44.4%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=102 (46.4%), SD=49.1±10.6</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>HLA-B27, n (%)</td>
<td>192 (87.2%)</td>
<td>9 (100%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=122 (55.5%), SD=71.8±15.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis, n (%)</td>
<td>119 (54.0%)</td>
<td>9 (100%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=77 (35.0%), SD=50.0±12.5</td>
<td></td>
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<td></td>
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<tr>
<td>Coxitis, n (%)</td>
<td>105 (47.7%)</td>
<td>7 (77.8%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>M=68 (30.9%), SD=41.2±9.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uveitis, n (%)</td>
<td>52 (23.6%)</td>
<td>4 (44.4%)</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>M=31 (14.1%), SD=20.5±4.7</td>
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<td></td>
</tr>
<tr>
<td>Uveitis, n (%)</td>
<td>5 (2.2%)</td>
<td>0</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>M=3 (1.4%), SD=2.0±1.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis, n (%)</td>
<td>24 (10.9%)</td>
<td>0</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>M=15 (6.8%), SD=8.0±3.8</td>
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</tbody>
</table>

### Conclusion:
Patients with AS and secondary AA amyloidosis are predominantly of male gender, who usually get sick in childhood, have 100% HLA-B27 positivity, peripheral arthritis, and coxitis.

### Disclosure of Interests:
None declared

### DOI:
10.1136/annrheumdis-2020-eular.3209

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### AB0720 SOLUBLE TRANSFERRIN RECEPTOR IN DIAGNOSIS OF IRON DEFICIENCY ANEMIA IN PATIENTS WITH SPONDYLOARTHRITIS

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### Background:
Anemia is a frequent hematological disorder in patients with rheumatic diseases. The main pathogenetic variants of anemia are anemia of chronic disease (ACD), iron deficiency anemia (IDA), and anemia of chronic disease with iron deficiency (ACD/IDA). The presence of systemic inflammation hinders to diagnose absolute iron deficiency, because standard tests of iron status are affected by it. Soluble transferrin receptors (sTfR) measurement and the calculation of the sTfR/log ferritin index (sTfR index) are recommended, but data about diagnostically significant levels of these indicators in patients with spondyloarthritis (SpA) is currently limited.

### Objectives:
To assess the diagnostic significance of sTfR and the sTfR index for detecting absolute iron deficiency in patients with SpA and anemia.

### Methods:
Complete blood count, standard iron metabolism parameters, C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) were evaluated in 68 patients with SpA. Serum concentration of sTfR was measured with enzyme-immunosorbed assay (ELISA) using sTfR ELISA kit (Biosource Inc, USA). The sTfR index was calculated by the formula sTfR/log ferritin. Anemia was defined using the World Health Organization criteria. Depending on the serum ferritin concentration, transferrin saturation, and CRP level, ACD, IDA, or combined anemia (ACD/IDA) were diagnosed. Disease activity was determined by the BASDAI (Bath Ankylosing Spondylitis Disease Activity Index) and ASDAS-CRP (Ankylosing Spondylitis Disease Activity Score based on CRP) scales. Receiver operating characteristic (ROC) analysis was performed with MedCalc.

### Results:
The comparative study between SG vs UG showed in UG a significant predominance of women (p=0.001, OR=5.78, CI:1.70-18.99). The common pattern in SG was episcleritis (84.21%) and scleritis (15.79%). In a large unselected series of IBD, we study the OM and assess; a) epidemiological, clinical features, b) the relationship with extraintestinal manifestations.

### Methods:
Study of all consecutive patients from a single University Hospital during the last 40 years with: a) IBD (CD and UC), and b) OM: uveitis and scleral pathology diagnosed by clinical features and slit-lamp.

### Results:
OM were present in 42 (2.9%) (25 women/17 men) (84 eyes) of 1442 IBD patients; OM included the uveitis group (UG) (n=23; 1.6%) and the scleral pathology group (SG) (n=19; 1.3%) (TABLE).

### Discussion of Interests:
None declared

### DOI:
10.1136/annrheumdis-2020-eular.3608

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### AB0721 OCULAR INVOLVEMENT IN INFLAMMATORY BOWEL DISEASE. STUDY OF 1442 PATIENTS FROM A SINGLE UNIVERSITY CENTER.

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### Background:
Inflammatory bowel disease (IBD), which includes Crohn’s disease (CD), and Ulcerative colitis (UC) are related to Spondyloarthropathies (SpA). IBD causes a significant prevalence of uveitis (2-10%) and OM as conjunctivitis, episcleritis, and scleritis. OM are well-stablished in SpA but not in IBD. It has been classically reported that whereas uveitis with SpA is predominantly anterior, unilateral, sudden, and limited; in IBD it is bilateral, posterior, insidious, and chronic (Lyons & Rosenbaum JT. Arch Ophthalmol 1997; 115:61-4).

### Objectives:
In a large unsellected series of IBD, we study the OM and assess; a) epidemiological, clinical features, b) the relationship with extraintestinal manifestations.

### Methods:
Study of all consecutive patients from a single University Hospital during the last 40 years with: a) IBD (CD and UC), and b) OM: uveitis and scleral pathology diagnosed by clinical features and slit-lamp.

### Results:
OM were present in 42 (2.9%) (25 women/17 men) (84 eyes) of 1442 IBD patients; OM included the uveitis group (UG) (n=23; 1.6%) and the scleral pathology group (SG) (n=19; 1.3%) (TABLE).

### Conclusion:
Both uveitis and episcleritis are equally frequent OM in IBD. Although uveitis is more frequent in IBD than in SpA, it is also anterior, unilateral, sudden and limited in contrast with published data from selected series.

### Disclosure of Interests:
None declared

### DOI:
10.1136/annrheumdis-2020-eular.4612

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### AB0722 LOSS OF GLYCOSEMINOLYCS OF LUMBAR INTERVERTEBRAL DISCS IN PATIENTS WITH ANKYLOSING Spondylitis

P. Sewer1, D. Abrar2, M. Frenken2, X. Baraliakos1, M. Schneider1, B. Ostendorf1, C. Schleicht2, Heinrich-Heine University, Department for Rheumatology, Duesseldorf, Germany; 2Heinrich-Heine University, Institute

### Background:
The most common pattern in SG was episcleritis (n=16; 84.21%) and scleritis (n=3). In UG, uveitis was typically anterior (n=18; 78.3%), unilateral (n=19; 82.6%), sudden (n=19; 82.6%), and limited (n=12; 52.2%). The comparative study between SG vs UG showed in UG a significant predominance of women and UC. Also, a non-significative higher frequency in Pyoderma gangrenosum, erythema nodosum and joint/axial flare was observed in SG. After a mean follow-up of 15.2±9.7 years, extraintestinal manifestations were observed in 100% of patients, being articular forms (n=16; 38.10%) the most common type. In addition, joint/axial flare is more related to the presence of uveitis (p=0.038).

### Conclusion:
Both uveitis and episcleritis are equally frequent OM in IBD. Although uveitis is more frequent in IBD than in SpA, it is also anterior, unilateral, sudden and limited in contrast with published data from selected series.

### References:

### Disclosure of Interests:
Lara Sanchez-Bilbao Grant/research support from: Pfizer, David Martinez-Lopez: None declared, Irigo Gonzalez-Mazon: None declared, Maria Jose Garcia-Garcia: None declared,Montserrat Rivero-Tirado: None declared, Beatriz Castro: None declared, Javier Crespo: None declared, Miguel A Gonzalez-Gay Grant/research support from: AbbVie, MSD, Speakers bureau: Pfizer, Abbvie, MSD, Ricardo Blanco Grant/research support from: AbbVie, MSD, and Roche, Speakers bureau: AbbVie, Pfizer, Roche, Bristol-Myers, Janssen, and MSD

### DOI:
10.1136/annrheumdis-2020-eular.4612