osteoporosis was found in 22 patients (55%), osteopenia – in 8 (20%), and norm – in 4 (10%) patients. The BMD values (g / cm²) in the group were as follows:

	N	Mean	Percentiles	
			25th	75th
BMD L1-L4	40	1,06	0,88	1,25
BMD Prox.Femur	32	0,56	0,61	0,81
BMD Forearm	34	0,48	0,43	0,54

Peripheral bone fractures were diagnosed in 15 (32.6%) patients – 9 men and 6 women; 25 (62.5%) patients had no fractures. For the first time, fractures were reported in patients aged from 33 to 69 years (mean 55.9±9.5). The localization of fractures was as follows: femur – in 8 patients (20%), forearm – in 6 (15%), shin bones – in 1 (2.5%) patients. Despite lower BMD rates in women, there were no significant differences in the frequency of fractures depending on sex. Correlation analysis (for Spearman) showed the relationship of fractures with age ($r = -0.31$, $p < 0.05$), femur BMD in general ($r = -0.53$, $p < 0.01$) and forearm BMD ($r = -0.44$, $p < 0.01$).

Conclusion: There is a high incidence of osteoporosis, mainly in the proximal femur and forearm in patients of the older age group with AKU. In the lumbar spine (due to the development of calcification of the intervertebral discs and ligamentous apparatus), osteoporosis is rarely detected, but the frequency of osteopenia is quite high. 32.6% patients had a history of skeletal bone fractures, and the sex of the patients did not affect the risk of fractures. The occurrence of fractures in patients with AKU is associated with low BMD values of the proximal femur.

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AB1043

AWARENESS OF THYROID EYE DISEASE, AN AUTOIMMUNE CONDITION, AMONG RHEUMATOLOGISTS

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Background: Autoimmune inflammatory conditions of the eye may be associated with rheumatic diseases such as rheumatoid arthritis, systemic lupus erythematosus, and granulomatosis with polyangiitis. This is also observed with thyroid eye disease (TED). Loss of immune tolerance to the thyroid stimulating hormone receptor has thyroidal consequences and nearly 40% of patients with Graves' disease also have clinically evident Graves' orbitopathy or TED.¹ TED results from tissue inflammation that causes retro orbital fat expansion² and extraocular muscle enlargement² and stiffening.³ Because the orbital cavity is bony and of limited volume, proptosis and, in severe cases, optic nerve compression, can result. In many patients, muscle changes also cause ocular motility issues and double-vision. Because TED can have a similar presentation to other inflammatory orbital diseases (e.g., granulomatosis with polyangiitis) and Graves' disease patients frequently have other autoimmune conditions (10% of Graves's patients also have rheumatoid arthritis),⁴ rheumatologists are likely to care for, or even diagnose, patients with TED.

Objectives: This analysis sought to understand rheumatologists' knowledge, and degree of participation in the treatment, of TED including referral patterns from ophthalmologists and endocrinologists for infusion therapies.

Methods: Rheumatologists practicing in the United States attended an educational session and agreed to complete a 12-item survey regarding TED awareness, referral patterns, and management.

Results: Of the 47 rheumatologists surveyed, 45 (96%) were familiar with TED. Ten (21%) physicians reported managing patients with TED, but the majority of physicians (62%) reported that they co-managed other autoimmune diseases in patients who also had TED. Additionally, 98% and 64% of polled rheumatologists had received referrals from ophthalmologists and endocrinologists, respectively, for autoimmune disease management or infusion therapy. Ophthalmology referrals for intravenous (IV) medication administration were most frequently for biologics (82%), but some referrals were also made for corticosteroids (2%) or other medication (13%) infusions. Only 23% of rheumatologists had administered a biologic specifically for TED (rituximab: 17%, tocilizumab: 2%, other: 4%), but 89% expressed an interest in administering a TED-specific monoclonal antibody therapy, awaiting FDA approval.

Conclusion: Nearly all surveyed rheumatologists were aware of the signs and symptoms of TED, although most did not actively manage or administer medication for TED. Given the high level of interest in infusing novel, TED-specific biologics, rheumatologists may become an integral part of TED patient

management with the approval of a new biologic, teprotumumab, for thyroid eye disease.

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AB1044

CLINICAL AND IMMUNOLOGICAL FEATURES OF A SERIES OF PATIENTS WITH RHUPUS

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Background: Since its first description in 1971 by Schur, many authors have discussed whether rhupus is an overlap syndrome between RA and SLE, a particular form of SLE with prominent and frequently erosive joint involvement, or if it is a distinct clinical and immunological entity. There are several published case series in medical literature describing the features of that uncommon syndrome that constitutes about 0.01-2% of all systemic rheumatic diseases.

Objectives: To describe demographic, clinical and immunological features of a series of patients with rhupus syndrome and to compare them with previously reported series in the literature.

Methods: Review of clinical records of patients attended in a Tertiary Care Rheumatology Unit that fulfil classification criteria for RA (either ACR 1987 or ACR/EULAR 2010) and SLE (either ACR 1997 or SLICC 2012). In addition, a manual search of patients with positivity for both anti-CCP (defined as >3 UI/mL) and specific SLE antibodies (either anti-DNAbs by IIF+ or anti-Sm by multiplex assay) was conducted. We excluded patients with known mixed connective tissue disease, drug-induced SLE as well as RA patients with anti-DNAbs+ or anti-Sm+ without clinical features of SLE.

Results: We identified 8 patients, all of them women (4 of Latin American origin, 3 Caucasians and 1 Arab) with a mean age at diagnosis of 35 years (range:19-63 years) and a mean duration of disease of 9 years (±10.5 years). RA and SLE were diagnosed simultaneously in 50% of cases (37.5% onset as RA and 12.5% as SLE, being the mean time between both diagnoses of 16.5 months in those cases). Immunological features of patients are summarized in Table 1. An erosive form of arthritis is present in 37.5%. As extra-articular involvement, 75% have skin lesions (photosensitivity, malar rash, oral ulcers and alopecia as major features) and 100% haematological alterations with lymphopenia (37.5% thrombopenia). Serositis (37.5%), renal (25% biopsy-proven lupus nephritis, 12.5% non-nephrotic proteinuria) and neurological (present only in one patient) involvement were less common findings. Most common therapies in our series were glucocorticoids (100% of cases, with a mean dose of 21.25 ± 13.5 mg/day at onset), antimalarials (87.5%) and methotrexate (87.5%). 50% of patients required biologic therapy (2 etanercept, 1 adalimumab, 1 rituximab) for inadequate disease control with conventional synthetic DMARDs.

	ANA (IIF titers)	Anti-DNAbs (IIF titers)	Anti-Sm	Anti-chromatin	RF (UI/mL)	Anti-CCP (UI/mL)	Anti-Ro	Anticardiolipin (UI/mL)	Anti-β2GPI (UI/mL)	Lupus anticoagulant
1	1/320	-	-	+	53	2	-	-	22 (IgM)	-
2	1/640	-	-	-	810	486	-	-	-	-
3	1/1260	-	-	-	1230	310	-	25.8 (IgM)	-	-
4	1/640	1/50	-	+	588	>300	-	-	28.5 (IgA)	-
5	1/160	-	-	-	232	11.1	+	148 (IgG) (Ro50)	160 (IgG), 111 (IgM), 42 (IgA)	+
6	1/160	1/50	-	+	230	>300	-	32.4 (IgM)	-	-
7	1/320	-	-	-	198	>300	+	19.5 (Ro52) (IgM)	-	-
8	1/160	-	+	+	170	>300	-	-	-	-

Conclusion: Prevalence of erosive arthritis in our patients is lower than previously reported, though as a limitation an imaging technique with a higher sensitivity for erosion detection than simple X-ray (such as US or MRI) was not available. Moreover, our series sample is small considering the low prevalence of this entity. The proportion of patients with simultaneous diagnosis of both RA and SLE is also higher (with a shorter interval between both diagnoses when this is not the case), so it is the proportion of patients receiving biologic therapy. The