Conclusion: To our knowledge, this is the first study demonstrating significantly lower scores among MDD relative non-MDD (based on PHQ-9) patients across all the 8 domains of LupusQoL; therefore, it adds to the current evidence that depression significantly impacts the quality of life of SLE. Predictors of MDD include older age, and involvement of the vascular, mucocutaneous, pulmonary, and musculoskeletal system. Additionally, a poor or fair description of self-rated health was a predictor of depression.

Disclosure of Interests: None declared

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AB1225

LIPID PROFILE COMPARISON IN RHEUMATOID ARTHRITIS AND PSORIATIC ARTHRITIS: A CASE-CONTROL STUDY

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Background: Rheumatoid arthritis (RA) and psoriatic arthritis (PsA) are autoimmune diseases, in both diseases it has been described that the main cause of morbidity and mortality is cardiovascular (CV) disease. Dyslipidemia is the most recognized CV risk factor. An association is recognized between the concentrations of total cholesterol (TC), high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C), total triglycerides (TG), atherogenic index (AI) and the risk of myocardial infarction (MI), stroke and fatal cardiovascular disease (CVD). The relationship between serum lipid levels and CVD risk is potentially paradoxical in RA but this relationship has not been clarified in PsA.

Objectives: To compare lipid profile between groups with RA, PsA and controls.

Methods: A cross-sectional observational study was designed, which included 95 patients between 45-75 years who fulfilled the CASPAR classification criteria for PsA, 95 patients between 45-75 years who fulfilled the ACR / EULAR 2010 classification criteria for RA and 95 age-matched controls. Concentrations of CT, HDL-C, LDL-C, TG and atherogenic index were compared between the groups. Clinical measures were compared using one-way ANOVA or Kruskal-Wallis tests. Post-hoc analysis was performed with Bonferroni's correction. A $p \leq 0.05$ was considered statistically significant. The data was analyzed using the SPSS version 25 software package.

Results: In our study, no significant difference in LDL-C was found between RA and PsA, however post-hoc analysis was performed where we found higher LDL-C levels among RA patients compared with controls (p 0.025). RA patients had higher HDL-C than PsA patients (p 0.006) but PsA had a higher HDL-C than controls (p 0.007). TC/HDL-C was higher in PsA than RA and controls (p 0.050). PsA patients were the group with the lowest HDL-C levels (p 0.007). In contrast RA were the groups with the highest HDL-C levels (p 0.007). (Table 1).

Table 1. Clinical parameters.

PARAMETER	RA	PsA	Controls	p
TC*	176.6 ± 37.2	176.3 ± 35.9	186.34 ± 33.172	0.089
TG**	132.7 (102.0-187.3)	131.0 (97.2-189.2)	118.35(88.2-162.25)	0.245
HDL-C**	50.7 (42.1-62.6)	46.7 (37.4-53.9)	51.7 (41.3-60)	0.007
LDL-C*	94.36 ± 21.70	97.71 ± 30.12	105.32 ± 31.35	0.025
TC/HDL-C**	3.41 (2.81-4.08)	3.74 (3.17-4.47)	3.49 (2.99-4.52)	0.050

*Data are reported in mean ± SD

**Data is reported in median (IQR)

Conclusion: Patients with inflammatory joint diseases have more adverse lipid profiles than controls.

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AB1226

PREDICTING CARDIOVASCULAR EVENTS IN PATIENTS WITH SPONDYLOARTHRITIS AND PSORIATIC ARTHRITIS: THREE RISK ALGORITHMS

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Background: Inflammatory joint disorders have an increased cardiovascular (CV) risk when compared with general population. In 2009, the EULAR task force advocated the use of a 1.5 multiplication factor for these risk prediction models in Rheumatoid Arthritis patients with specific characteristics. The SCORE was not modified in patients with Psoriatic Arthritis (PsA) and Spondyloarthritis (SpA) in accordance with the present EULAR recommendations.

Objectives: To assess the accuracy of several CV risk algorithms to predict an event and determine its sensibility and specificity.

Methods: A retrospective analysis of PsA and SpA patients, followed in our department in Local Health Unit of Guarda during one year (2019) was done. We determined CV risk profile of our patients using the following data: gender, age, smoking status, blood pressure, lipid values and diabetes mellitus status. These variables were used to calculate risk prediction algorithms such as Framingham, the American College of Cardiology/American Heart Association (ACC/AHA) risk score and the Systematic Coronary Risk Evaluation (SCORE). Discriminatory ability for CV risk prediction was evaluated by the area under the ROC curves. Sensibility and specificity were calculated for low-to-intermediate and intermediate-to-high risk cut-offs. Cut-off values that mark the high risk were defined in 5% for SCORE, 20% for Framingham and ACC/AHA.

Results: 112 caucasian patients were included, 61% female with a mean age of 52.15±14.18 years and mean BMI of 27.11±4.81kg/m². 7 patients weren't eligible to apply these cardiovascular scores. 8 patients were identified with non-fatal cardiovascular events (2 cases of stroke, 5 cases of myocardial infarction and 1 case of thrombophlebitis). 69 patients diagnosed with SpA and 43 with PsA, five CV events identified in SpA patients and three in PsA patients. Area under the ROC in SpA were 0.729 (95% CI 0.461 to 0.996) for SCORE, 0.839 (95% CI 0.735 to 0.943) for Framingham and 0.804 (95% CI 0.683 to 0.925) for ACC/AHA. Area under the ROC in PsA patients were 0.603 (95% CI 0.327 to 0.879) for SCORE, 0.660 (95% CI 0.326 to 0.995) for Framingham and 0.804 (95% CI 0.683 to 0.925) for ACC/AHA. Sensibility and specificity were discriminated in table 1.

Table 1. Sensibility, specificity, positive predictive value (PPV) and negative predictive value (NPV) of CV risk algorithms

	Sensibility (%)	Specificity (%)	PPV (%)	NPV (%)
SCORE > 1%				
SpA	75	63	18	96
PsA	100	41	5	100
SCORE > 5%				
SpA	NA	NA	NA	NA
PsA	0	93	0	97
Framingham >10%				
SpA	83	78	28	98
PsA	50	51	5	95
Framingham >20%				
SpA	33	86	20	93
PsA	50	69	8	96
ACC/AHA >5%				
SpA	67	77	29	94
PsA	100	44	9	100
ACC/AHA >20%				
SpA	17	86	14	88
PsA	50	83	14	97

Conclusion: A good discrimination between patients with or without CV events has been demonstrated by area under the ROC curve, particularly to SpA patients. In PsA, the sample was smaller, which represents a limitation in this study. SCORE >5% did not identify CV events, therefore sensibility couldn't be calculated. Overall, the algorithms studied presented a low sensibility, underestimating CV risk. This could be explained since disease-related factors are not reflected in these scores. In our opinion, better algorithms are needed to correctly assess cardiovascular risk algorithms for SpA and PsA, since the majority of the events occur in patients with low-intermediate risk.

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AB1227

PREVALENCE OF RHEUMATIC MUSCULOSKELETAL DISORDERS IN A RURAL AREA OF UPPER EGYPT: WHO-ILAR COPCORD BASED COMMUNITY STUDY

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