Table 1. Current Treatment Information of the Patients

Current Treatment Information	
DMARD	26
Colchicine	23
Adalimumab	21
Etanercept	10
NSAID	4
Tocilizumab	3
Cyclophosphamide	3
Rituximab	2
Prednisolone	7
Mycophenolate Mofetil	1
Canakinumab	1

Seven patients had FMF related attacks. In addition to attacks, one FMF patient had bilateral ankle pain and one patient had leg pain. One patient out of three diagnosed with Takayasu's disease was still symptomatic. One patient had uveitis-related symptoms. One patient diagnosed with SLE had skin dryness. Furthermore, there were patients with sequelae formation. One patient diagnosed with oligoarticular JIA (oJIA) had bilateral hip sequela with the additional left hip prosthesis. One oJIA patient had micrognathia, and one had left knee sequela. One pJIA patient had small joint sequelae. One sJIA patient had bilateral hip sequelae. One jSPA patient had enthesopathy. One FMF patient had proteinuria due to amyloidosis formation. Another FMF patient had hip surgery due to sequela.

Conclusion: Our center had patients with a variety of conditions with different natures of diseases. EULAR recommends the transition process to start no later than 14 years of age; however, this process started at the mean age of 21 in our patients. In most of these patients, especially the ones diagnosed with FMF, the control of disease activity was maintained. The transition of these different clinical entities might require certain amendments to the standard of care. For future references, we will be able to understand more about the adulthood prognosis of these clinical entities.

Disclosure of Interests: None declared

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AB1326-HPR TOBACCO ADDICTION IN PEOPLE WITH RHEUMATOID ARTHRITIS – FROM THE PERSPECTIVE OF PATIENTS

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Background: Smoking is one of the most significant modifiable exosomes risk factors for rheumatoid arthritis (RA) (1). Studies suggest that 25-30% of people with RA in Denmark smoke (2). This is almost twice as many as in the background population in Denmark. People with RA have a significant increased risk of severe comorbidity including cardiovascular disease. In addition, there are indications that smokers with RA have a poorer effect of the medical inflammatory treatment compared to non-smokers, and consequently more difficult to achieve remission of the disease activity (3). Tobacco addiction is complex and can be a challenge in smoking cessation. In addition to physiological dependence, habits and social and environmental factors may influence addiction. Tobacco smoking is associated with an addiction to nicotine and it is unexplored how this addiction appears in people with RA.

Objectives: The aim of this study was to examine from the patient's perspective how tobacco addiction appears in people with rheumatoid arthritis.

Methods: We conducted a qualitative study based on a hermeneutics approach. People with RA who previously had participated in a randomized controlled study (4) about smoking cessation conducted at the Center for Rheumatology and Spine Diseases at Rigshospitalet, Denmark were recruited for semi-structured interviews.

Results: In total, 12 people with RA (50% female) were included in the study. The median age was 62 years and median RA disease duration was 12 years. The degree of physical dependence measured by Fagerströms Test for Nicotine dependence (FTND) was on average: 4.9 (score: 0-10, 0=nonphysical dependence).

Three categories of how tobacco addiction appeared emerged during the analysis: 1) *It develops into ingrown habits* referring to the fact that smoking already in adolescence contributes to the development of specific physical, mental and social smoking behavior. Not all individuals considered themselves addicted to nicotine as they did not necessarily connect the nicotine to the ingrown habits. 2) *The body craves for nicotine* referring to nicotine proved calming, while a lacking or insufficient dose caused withdrawal symptoms. Furthermore, smoking became a habit where a craving for smoking occurred in certain situations. 3)

Ambivalence – for and against referring to the physical dependence and smoking habits making a smoking cessation difficult. Dependency to nicotine and challenges to quit smoking led to a feeling of ambivalence and a lack of control.

Conclusion: Tobacco addiction appeared as a physical dependence and a habit, which, during a smoking cessation, led to ambivalent feelings. Therefore, based on this study, there is still a need for health professionals to talk to patients about smoking. But also, a need to articulate the complexity of addiction in order to support for smoking cessations. Information should be strengthened in the clinical practice in relation to nicotine's implication in tobacco addiction as well as the consequences of tobacco smoking for individuals with RA.

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AB1327-HPR SELF-ASSESSMENT OF ORAL HEALTH STATUS IN RHEUMATOID ARTHRITIS, SYSTEMIC LUPUS ERYTHEMATOSUS AND CONTROLS

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Background: Different periodontal disorders have been associated with the development of multiple rheumatic diseases, encouraging the production of citrullinated proteins and creating a proinflammatory state with an increase in oral and systemic symptomatology.

The Geriatric/General Oral Health Assessment Index (GOHAI) survey has been used as a self-assessment tool where studies have found a diminished quality of oral health in Rheumatoid Arthritis (RA).¹

Objectives: Compare the behavior of GOHAI survey in RA, Systemic lupus erythematosus (SLE), and controls in a Rheumatology center at Northeast Mexico.

Methods: We performed a descriptive study of patients with RA and LES who answered the Spanish version of GOHAI survey. A control group was also included.

GOHAI survey consists of 12 Questions with Likert answers evaluating problems related to periodontal disease in the last 3 months.

Questions 1-4 evaluate physical function, 6, 7, 9-11 psychosocial status and 5, 8 and 12 pain.

Results: Sixty RA patients, 32 SLE patients and 46 controls were included. Groups were adjusted by sex and age.

GOHAI survey presented a total mean of 23.4 in RA, 22.06 in SLE and 21.54 in controls with a maximum score of 60 points.

When analyzing the survey in physical function and psychosocial status a statistical significant difference was found when comparing RA group to controls.

Table 1. Comparison between GOHAI index scores in RA, SLE and control groups

	RA n= 60	SLE n= 32	Controls n=46	
	Median (SD)	Median (SD)	Median (SD)	RA vs SLE and Controls groups
Age	51.27 (15.84)	37.03 (14.14)	41.07(11.25)	0.17
Sex	58 (96.67%)	29 (90.62%)	42 (91.3 %)	
1. Limit the kinds of food consumed	1.87 (1.14)	1.78 (1.15)	1.78 (0.81)	
2. Trouble biting or chewing	1.96 (1.2)	1.91 (1.27)	1.78 (1)	
3. Able to swallow comfortably	2.2 (1)	1.81 (1.47)	1.41(1.15)	
4. Unable to speak clearly	1.63 (1)	1.13 (0.42)	1.24(0.57)	
5. Able to eat without discomfort	1.9 (1.17)	1.59 (0.98)	1.76 (0.79)	
6. Limit contact with people	1.45 (0.9)	1.34 (0.75)	1.3 (0.73)	
7. Pleased with appearance of teeth	2.85 (1.65)	3.2 (1.79)	2.22(1.25)	
8. Use medication to relieve pain	1.83 (1.08)	1.94 (1.13)	1.87 (0.88)	