Table 1. Characteristics of the psoriasis cohort starting exclusively TNFi or methotrexate

	Incident PsA n = 35	PsA negative n = 119	p-value
Treatment [n (%)]			0.37
TNFi	18 (51.4)	51 (42.9)	
Methotrexate	17 (48.6)	68 (57.1)	
Sex [n (%)]			0.24
Female	21 (60.0)	58 (48.7)	
Male	14 (40.0)	61 (51.3)	
Age [median (IQR)]	47.0 (39.4, 59.7)	48.9 (35.3, 61.7)	0.71
Pso manifestations [n (%)]			
Nail pitting	27 (77.1)	51 (42.9)	<0.01
Scalp psoriasis	31 (88.6)	105 (89.0)	0.95
Inverse psoriasis	14 (40.0)	37 (31.09)	0.33
BSA [median (IQR)]	6 (3, 15)	12 (5, 22)	0.06
BMI [median (IQR)]	31.7 (25.9, 40.4)	29.1 (26.3, 34.7)	0.30
Therapy duration (years)			
TNFi [median (IQR)]	4.38 (1.34, 8.13)	2.26 (0.76, 5.82)	0.29
Methotrexate [median (IQR)]	2.44 (0.06, 3.44)	0.94 (0.27, 2.39)	0.43

Disclosure of Interests: Noah Lininger: None declared, Sarah Siegel: None declared, Sonam Kiwalkar: None declared, Kevin Winthrop Grant/research support from: Bristol-Myers Squibb, Consultant of: AbbVie, Bristol-Myers Squibb, Eli Lilly, Galapagos, Gilead, GSK, Pfizer Inc, Roche, UCB, Alex Ortega Loayza Consultant of: Adviser board for Janssen, Atul Deodhar Grant/research support from: AbbVie, Eli Lilly, GSK, Novartis, Pfizer, UCB, Consultant of: AbbVie, Amgen, Boehringer Ingelheim, Bristol Myer Squibb (BMS), Eli Lilly, GSK, Janssen, Novartis, Pfizer, UCB, Speakers bureau: AbbVie, Amgen, Boehringer Ingelheim, Bristol Myer Squibb (BMS), Eli Lilly, GSK, Janssen, Novartis, Pfizer, UCB
DOI: 10.1136/annrheumdis-2020-eular.4983

FRI0556

INCREASED RISK OF MORTALITY AND CANCER IN SYSTEMIC LUPUS ERYTHEMATOSUS: RESULTS FROM A LUPUS COHORT STUDY FROM 1998 TO 2015

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Background: Systemic lupus erythematosus (SLE) is a chronic systemic autoimmune inflammatory disease with increased risk for mortality and cancers possibly because of the effects of systemic inflammation and immunodeficiency due to disease itself and/or cytotoxic agents for SLE management. Although there has been improvement in the prognosis of SLE over decades with the treatment advance including standardized treatment strategy for lupus nephritis and less cytotoxic agents, the improvement also is fixed nowadays.

Objectives: In this study, we are to investigate the mortality and cancer of SLE patients in a longitudinal SLE cohort and compare the mortality ratio and incidence of cancer with general population over time.

Methods: This study was conducted in Hanyang BAE lupus cohort during the period of 1998 to 2015. Mortality data and malignancy data were derived in connection with data from the Korean National Statistics Office and the Korea Central Incidence Database, respectively. The Standardized Mortality Ratio (SMR) and Standardized Incidence Ratio (SIR) was estimated yearly by dividing the observed number deaths/cancers by the expected number of deaths/cancers of age- and sex- matched general population from matched year.

Results: Mortality data were available in 1284 patients and total 71 deaths were observed. The most common cause of death was SLE itself (52.1%) followed by infection (18.3%), cerebrovascular disease (8.5%) and suicide (7.0%). The total age and sex adjusted SMR was 3.4 [95% CI (Confidential Interval) 2.6-4.1]. When we conduct subgroup analysis by age, the sex-adjusted SMR was significantly increased in young and middle aged adult patients: the SMR in patients younger than 20 was 12.2, but it was not significant due to the small number of young patients (observed death 3, expected death 0.3, 95% CI 0-26.0). The adjusted SMR in patients aged 20-39, aged 40-59 and aged over 60 were 9.8 (observed death 35, expected death 4.8, 95% CI 6.5-13.0), 3.7 (observed death 24, expected death 11.5, 95% CI 2.2-5.2), and 1.0 (observed death 9, expected death 10.3, 95% CI 0.3-1.6), respectively. Compared with alive patients, died patients had more serositis and more neurologic disorder according to American

College of Rheumatology classification criteria for SLE despite the shorter observational period (5.6 years vs. 9.4 years).

Malignancy data were available in 1,020 patients and 56 primary cancers were diagnosed. Solid tumor was developed in 51 patient and hematologic malignancy was developed in 5 patients (3 non-Hodgkin's lymphoma, 1 solitary plasmacytoma and 1 acute lymphoblastic leukemia). Thyroid cancer was the most common solid cancer (24 patients) followed by colorectal (5 patients), breast (4 patients), cervical cancer (4 patients) and hepatocellular carcinoma (3 patients). The total age and sex adjusted SIR was 1.1 (95% CI 0.8-1.4).

Conclusion: Patients with SLE had higher risk of mortality than general population and the younger patients had the higher risk of mortality. The leading cause of death was SLE itself followed by infection and cerebrovascular disease. The risk for cancer in patient with SLE was similar with that of general population.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.2557

FRI0557

IN INDIVIDUALS AT-RISK OF RHEUMATOID ARTHRITIS, ULTRASOUND BONE EROSIONS AT THE V METATARSOPHALANGEAL JOINTS ARE THE MOST PREDICTIVE FOR THE DEVELOPMENT OF CLINICAL ARTHRITIS.

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Background: While the central role of bone erosions in the pathogenesis and diagnosis of patients with rheumatoid arthritis (RA) is widely recognized, their prevalence, pattern, and relationship with subclinical synovitis in individuals at-risk of RA (positive autoantibodies without clinical arthritis) is not well understood.

Objectives: To investigate, in individuals at-risk of RA, the prevalence and distribution of ultrasound (US) bone erosions, their correlation with subclinical synovitis at joint level, and their association with the development of inflammatory arthritis (IA).

Methods: Baseline US scans of 2nd generation anti-cyclic citrullinated peptide (CCP) positive at-risk subjects with musculoskeletal symptoms (without clinical arthritis) taking part in the Leeds CCP study were analyzed. The presence of bone erosions was evaluated in the classic sites for RA damage: the II and V metacarpophalangeal (MCP) joints, and the V metatarsophalangeal (MTP) joints¹. US synovitis was defined as synovial hypertrophy (SH) ≥ 2 or SH ≥ 1 + power Doppler signal ≥ 1 ². Only subjects with ≥ 1 follow-up visit were included in the progression analysis (n=400). Progression to IA was defined as the development of clinical synovitis in ≥ 1 one joint.

Results: US bone erosions: prevalence, distribution, and association with sub-clinical synovitis

A total of 2514 joints, in 419 subjects were evaluated.

Bone erosions were found in ≥ 1 joint in 41/419 subjects (9.8%), in 55/2514 joints (2.2%). The prevalence of bone erosions was significantly higher in the V MTP than

Table 1.

	Ever		At 1 year		At 3 years	
	HR (95%CI)	P value	HR (95%CI)	P value	HR (95%CI)	P value
Presence of bone erosion in ≥ 1 joint (any joint)	3.98 (1.82-8.7)	<0.01	3.57 (1.7-7.5)	<0.01	3.48 (1.63-7.4)	<0.01
- in the II MCP joints	2.4 (0.52-11.08)	0.26	1.07 (0.2-5.76)	0.94	1.67 (0.38-7.04)	0.5
- in the V MCP joints	1.37 (0.06-31)	0.85	0 (N/A)	1	0 (N/A)	1
- in the V MTP joints	4.79 (1.97-11.63)	<0.01	5.23 (2.32-11.8)	<0.01	5.43 (2.28-12.92)	<0.01
Presence of bone erosion and synovitis in the same joint (any joint)	3.9 (1.19-12.77)	0.02	6.03 (2.07-17.55)	<0.01	3.91 (1.29-11.85)	0.02
Presence of bone erosion and synovitis in the same V MTP joint	5.08 (1.37-18.9)	0.02	7.03 (2.28-21.71)	<0.01	4.89 (1.48-16.19)	<0.01
Presence of bone erosion in >1 joint (any joint)	10.63 (1.87-60.42)	<0.01	5.68 (1.66-19.5)	<0.01	7.26 (1.67-31.66)	<0.01

IA free survival rates are showed in Figures 1 and 2.