Disease Comorbidity Index (RDCI). RACI consists of 31 comorbidities grouped into 11 categories: DAS 28 >3.6, local inflammation, smoking, tumors, systemic involvement, infection, vascular disease, bone health, mood, metabolic and cardiovascular disorders (score range 0-36). RDCI consists of 11 comorbidities (categories according to ICD-10) and a formula to calculate it (range 0-9). For both indexes; higher score, greater comorbidity.

Results: In this cross-sectional study, 345 patients were evaluated, of which 176 were included, 85.8% of the patients were female and the mean age was 52.7 ± 10.9 years; 31.2% of the cases finished primary school, the median of disease duration was 9 years (1-40), the mean DAS28 3.8 ± 1.4 , and the mean CDAI 12.4 ± 11.3 . 52.3% of the patients received treatment with glucocorticoids, 60.8% with NSAID, 60.2% with methotrexate, 39.2% with leflunomide, 17.6% with biologic DMARDs and 5.6% with tofacitinib. 90.3% of the patients (95% CI 84.8, 94.3) presented some comorbidity measured by RACI. The average score was 4.7 ± 3.4 and the most frequent comorbidity were: elevated DAS28 (40.9%), dyslipidemia (38.1%), AHT (36.4%), prednisone >5 mg/d in 31.8%, endocrinopathies 19.3%. 73.3% of the patients had more than one comorbidity. Regarding RDCI, 47.2% of the cases presented some comorbidity with an average score of 0.95 ± 1.3 ; the most frequent were: AHT 36.4%, lung disease 12.5% and diabetes 8%. The oldest patients had more than one comorbidity (RACI), and also presented a higher HAQ score than those with only one ($p < 0.0001$). Higher RACI score was associated with higher CDAI ($p < 0.001$) and the use of glucocorticoids ($p = 0.008$).

Conclusion: The prevalence of comorbidities in RA by RACI was elevated (90.3%) and 73.3% of the patients presented more than one comorbidity. The patients with the highest RACI score had higher disease activity and used glucocorticoids more frequently.

Disclosure of Interests: None declared

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FRI0604-HPR IS STRESS A TRIGGER FOR THE DEVELOPMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS?

Y. Soria Curi¹, A. L. Barbaglia¹, L. Gonzalez Lucero¹, M. C. Bertolaccini¹, H. R. Sueldo¹, S. M. Mazza¹, M. L. Leguizamón¹, G. V. Espasa¹, M. Pera¹, V. I. Bellomio¹. ¹Hospital Ángel C. Padilla, Tucumán, San Miguel de Tucumán, Argentina

Background: Systemic Lupus Erythematosus (SLE) implies multifactorial psychological stress. Although stress has been spreaded as a "trigger" for the onset or flare of connective tissue diseases, there is controversial evidence of the association between stress and the diagnosis of SLE.

Objectives: To assess the frequency of stressors and vital events in patients with SLE and their relationship with the diagnosis.

Methods: A descriptive cross-sectional study was conducted. It were included patients over 18 years old with SLE diagnosis (ACR/SLICC criteria), attended in the Rheumatology Unit between May and August 2019; and 101 patients without any autoimmune disease. Demographic and disease-related variables were studied. The Holmes and Rahe Vital Events scale (43 questions) was used to evaluate vital events and measure the magnitude of stress that a person has experienced for a while and predict the onset of SLE. The sum of the scores indicates the magnitude of vital stress experienced by a person and the predisposition to acquire a disease. It was classified as: <150: small risk of illness due to stress; 150-299: moderate risk; and ≥ 300 : high risk.

Results: 94 patients with SLE were included, of which 94% were women. The mean age was 36.3 ± 10.3 years. 41.9% of the cases had a family history of rheumatic disease and 31.2% of them were unemployed. During the year before the diagnosis of SLE, 48.4% of the patients suffered a stressful situation, the most frequent cause was the death of a close family member (44.1%). Patients with SLE presented significantly higher stress scores than the healthy group (140 ± 27 vs. 45.1 ± 43 , $p = 0.0001$); 54.8% of patients with SLE had a score <150; 23.65% between 150-299; and 10.75% ≥ 300 . The number of patients with SLE was higher in the moderate and high risk categories (>150) than the healthy group (34% vs. 2%, $p = 0.0001$). When studying the Holmes and Rahe scale factors individually, patients with SLE had a higher frequency of situations related to: death of the couple ($p = 0.029$), death of a close relative ($p = 0.0001$), injury or personal illness ($p = 0.006$), change in living conditions ($p = 0.0001$) and poor relationship with the couple ($p = 0.017$).

Conclusion: Patients with SLE presented high frequency of stressful situations before diagnosis (48.4%), and higher scores compared to the healthy group. The death of a close family member was the most frequent stressful event.

Disclosure of Interests: None declared

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FRI0605-HPR MORTALITY AND SURVIVAL IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN ARGENTINA. A MULTICENTER STUDY ON BEHALF GESAR-LES

M. C. Bertolaccini¹, Y. Soria Curi¹, L. Gonzalez Lucero¹, G. V. Espasa¹, A. L. Barbaglia¹, H. R. Sueldo¹, M. L. Leguizamón¹, S. M. Mazza¹, M. Santana¹, L. M. Galindo¹, R. Águila Maldonado², M. García², D. Capelusnik³, R. Rojas Tessel⁴, E. Picco⁴, M. E. Crespo Espindola⁴, R. Calvo⁵, S. Roverano⁵, M. Cosatti⁶, C. Pisoni⁶, P. Avila⁷, M. Micelli⁷, M. Hu⁸, L. Alascio⁷, C. Goizueta⁹, V. I. Bellomio¹. ¹Hospital Ángel C. Padilla, Tucumán, San Miguel de Tucumán, Argentina; ²Hospital Interzonal General de Agudos General José de San Martín, La Plata, La Plata, Argentina; ³Psychophysical Rehabilitation Institute, Ciudad Autónoma de Buenos Aires, DQG, Argentina; ⁴Sr Hospital del Milagro, Salta, Argentina; ⁵Provincial Hospital Dr. José María Cullen, EQZ, Argentina; ⁶University Institute CEMIC, EFA, Argentina; ⁷Hospital General de Agudos José María Ramos Mejía, ADC, Argentina; ⁸Hospital General de Agudos José María Penna, JLR, Argentina; ⁹Sanatorium July 9 SA, San Miguel de Tucumán, Argentina

Background: The mortality rate in patients with systemic lupus erythematosus (SLE) is 2–3 times higher than in the general population. However, survival in these patients has improved significantly and is currently 95% at 5 years according to different studies. Since the last 20 years, there are no new reports on this issue in Argentina.

Objectives: To analyze the factors associated with mortality, survival and causes of death in patients with SLE.

Methods: Longitudinal - multicenter study, in which 10 rheumatology centers of Argentina participated. Patients with SLE (ACR 1997 and / or SLICC 2012 criteria) with a minimum follow-up of 6 months monitored between January 2008 and December 2018 were included. Demographic, clinical, laboratory, therapeutic variables (treatments received during the evolution of the disease and within 60 days prior to death or last control); mortality, causes of death and survival at 5, 10 and 20 years were evaluated. Statistical analysis: descriptive statistics, Kaplan-Meier survival curves and Cox regression model.

Results: Three hundred and eighty two patients were included; 90% women and 82% mestizos. The mean of evolution time of SLE was 4.1 ± 6.7 years. The mean age at the last control or death was 37.2 ± 12.7 years, SLEDAI 3.2 ± 4.2 and SLICC 1.2 ± 1.9 .

Mortality was 12% (95% CI [8-15]) and the causes of death were: Infections (27), cardiovascular disease (6), SLE activity (3), catastrophic antiphospholipid syndrome (2) and other causes (8). Using the variables associated with mortality in different Cox regression models, the variables that increased the risk of death significantly were: renal involvement (RR 3.3), cardiac involvement (RR 2.7), central nervous system involvement (RR 2.1), arterial thrombosis (RR 2.3), hyperlipemia (RR 2.4), number of infections (RR 1.2) and last SLEDAI (1.1).

The time of HCQ use greater than 36 months decreased the risk of death in this cohort by 40% ($p = 0.03$). Prednisone (maximum dose and time) was not associated with mortality ($p = NS$). When analyzing the last treatment and adjusting it for final SLEDAI, HCQ was a mortality protection factor (RR 0.4) while the use of cyclophosphamide alone or associated with prednisone was a risk factor for death (RR 5.2).

Significant differences were found when analyzing the causes of death according to the SLE evolution time ($p = 0.017$): patients who died from infection had less evolution time (Me 2.25 years), than those who died due to cardiovascular causes (Me 10 years) or SLE activity (Me 15 years). In this cohort of patients, survival was 93% at 5 years, 88% at 10 years and 72% at 20 years.

Conclusion: Mortality in this series of patients was 12% and infection was the leading cause of death. The use of HCQ for a period greater than 36 months, decreased the risk of death 40%.

Disclosure of Interests: None declared

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FRI0606-HPR REMISSION IN SYSTEMIC LUPUS ERYTHEMATOSUS, WHAT IS THE IMPACT ON ACCUMULATED DAMAGE?

F. J. Hüttmann¹, A. L. Barbaglia¹, L. Gonzalez Lucero¹, H. R. Sueldo¹, M. C. Bertolaccini¹, S. M. Mazza¹, Y. Soria Curi¹, M. L. Leguizamón¹, G. V. Espasa¹, L. M. Galindo¹, M. Santana¹, V. I. Bellomio¹. ¹Hospital Ángel C. Padilla, San Miguel de Tucumán, Argentina

Background: The objective of the treatment in rheumatic diseases is to achieved the remission or minimal disease activity of these patients. Previous studies in Systemic Lupus Erythematosus (SLE) showed that reaching remission had a positive impact on the prognosis of the disease.

Objectives: To determine the frequency of remission in a cohort of patients with SLE.

To evaluate the effect of disease activity on accrual damage.

Methods: A retrospective study was carried out from January 2010 to December 2018. Clinical records of patients with SLE (ACR criteria 1982/97) were reviewed considering baseline visit as the first clinical or control visit of 2010. For subsequent visits, data were collected annually until 2018. SLE activity was defined for each visit according to GLADEL's definition: 1- Remission Without Treatment (RwT): SLEDAI 0, without prednisone or immunosuppressive drugs (IS); 2- Remission on Treatment (RoT): SLEDAI 0, prednisone up to 5mg/day or immunosuppressive drugs in maintenance doses; 3- LDAS (Low Disease Activity Status): SLEDAI ≤ 4 , prednisone up to 7.5mg/day and/or IS in maintenance doses; 4- Non-Optimal Activity Control (NOC): SLEDAI > 4 , prednisone > 7.5 mg/day and/or IS in induction dose. The use of hydroxychloroquine was allowed for all groups. For the analysis, patients who remained in remission (with and without treatment) or LDAS for at least 75% of the follow-up time were grouped and compared with patients who remained active during that same period. Demographic, laboratory, treatment related variables and death were studied. Accrual damage was assessed with SLICC / SDI. Patients with less than two annual visits were excluded.

Statistical analysis: descriptive measures, Test T, Mann Whitney, Chi2 Test, Fisher's exact test, bivariate correlation, logistic regression model with mixed effects.

Results: Two hundred eighty-five medical records were reviewed and 100 patients with SLE were included, 89% women, mean age at baseline visit 38.5 ± 12 years old and mean time of disease 9.3 ± 7.3 years. The average SLEDAI and SLICC/SDI baseline scores were 3.7 and 0.8 respectively. The SLICC/SDI score at last visit was 2.2 and the average SLICC/SDI change (Δ SLICC) compared to baseline visit score was 1.4 ± 1.6 .

The prevalence of patients who were in remission for at least 75% of the follow-up time was 38% [95% CI 26.6, 45.4]. NOC patients categorized at baseline visit had the highest Δ SLICC (p 0.0001). The Δ SLICC was significantly lower in patients who were at least 75% of the follow-up time in remission (p 0.01) or LDAS (p 0.01) compared to those with NOC. In the Logistic Regression Model, the chance of changing the SLICC/SDI score was 2.9 times higher for the NOC group than for RwT.

Conclusion: The frequency of remission in this cohort of patients with SLE was 38%.

Worse control of disease activity, was associated with higher accumulated damage.

Disclosure of Interests: None declared

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FRI0607-HPR FREQUENCY AND PATIENTS BELIEFS ON VACCINATION IN RHEUMATIC DISEASES

M. Viola¹, A. Benitez¹, C. Garbarino¹, G. Rodriguez¹, F. Benavidez¹, C. Peon¹, E. S. Blanco¹, H. Molina¹, G. Gómez¹, G. Redondo¹, M. Delavega¹, D. Mata¹, A. Riopedre¹, O. Messina¹. ¹Hospital General de Agudos Dr. Cosme Argerich, Ciudad Autónoma de Buenos Aires, Argentina

Background: Infectious diseases are increased in patients with rheumatic disorders; vaccination improves morbidity and mortality

Objectives: The aim of this study was to describe the frequency of vaccination in patients with rheumatic disorders and to compare the results with those obtained in 2009 and 2013 in a similar population. We also identified factors leading to lack of vaccination and patients beliefs on vaccines.

Methods: Multicentric cross sectional study in patients with autoimmune diseases from external rheumatology offices. Evaluation of vaccination status and patients' knowledge about vaccines were studied. A comparative analysis was carried out with the series registered in 2009 and 2013 in a similar population.

Results: 179 patients (158 female, 88.3% and 21 male, 11.7%) were evaluated. Median age was 52 years. Main pathologies were: Rheumatoid Arthritis 65.9% (n:118), Systemic Lupus Erythematosus 11.7% (n:21), Systemic Sclerosis 3.9% (7), Sjogren Syndrome n = 3.4% (n:6), other diseases 15% (n: 27). Median disease duration: 8.87 years. Ninety three percent of patients (n:167) were taking immunomodulators and 36.8% (n: 66) were using oral corticosteroids (20mg/day or less); 26.8% patients (n: 48) were receiving biological therapies. Vaccination frequency in the population was: Influenza 82% (147); 13-valent conjugate pneumococcal 69.3% (124), 23-valent pneumococcal 64.2% (115) and hepatitis B 62% (111). Comparative with 2009 and 2013 series there was an increase in the rate of vaccinated patients: influenza (82% vs. 39,1% and 74,2% respectively), antineumococcal (64% vs. 17% and 29%) and hepatitis B (62% vs. 6,7% and 26,7%).

Reasons for non-vaccination were absence of medical indication (41% of patients for hepatitis B; 32% for 23-valent pneumococcal; 38% for 13-valent pneumococcal and 34% for influenza).

139 patients (77, 7%) knew the benefits of vaccines, 164 (91, 6%) thought vaccines are useful; 134 (74,9%) reported that vaccines may decrease dying probability, 155 (86,5%) thought that vaccines are effective to prevent diseases and 149 patients (83,2%) believed that they prevent serious infections. 71 patients (39%) believed that vaccines can lead to serious consequences and 99 (55,3%) that they are more likely to acquire infections than the rest of the population.

Conclusion: Frequency of vaccination has increased since 2009 but there is still misinformation regarding vaccines risks and benefits. Promotion and information is essential to improve adherence.

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FRI0608-HPR SEVERITY AND PREDICTORS OF PAIN INTENSITY AND HAND DISABILITY IN PATIENTS WITH TRAPEZIOMETACARPAL OSTEOARTHRITIS

T. Hamasaki^{1,2,3}, P. Harris^{1,2}, N. Bureau^{1,2,3}, N. Gaudreault^{4,5}, N. Patenaude^{4,5,6}, M. Choinière^{2,3}. ¹CHUM Hospital (Université de Montréal), Montréal, Canada; ²Université de Montréal, Montreal, Canada; ³Centre de recherche du CHUM (CRCHUM), Montreal, Canada; ⁴Université de Sherbrooke, Sherbrooke, Canada; ⁵Centre de recherche du CHUS (CRCHUS), Sherbrooke, Canada; ⁶CHUS Hospital (Université de Sherbrooke), Sherbrooke, Canada

Background: Trapeziometacarpal osteoarthritis (TMO) is one of the most prevalent and painful forms of hand osteoarthritis.¹ It limits thumb mobility,² reduces hand functions, and manual activities.¹ Yet, no study has exhaustively documented the characteristics of this pathology using a biopsychosocial approach (e.g., pain, disability, psychological well-being, pain-related catastrophic thinking, quality of life). Furthermore, radiographic TMO severity and symptomatology are only weakly to moderately correlated.^{3, 4} The extent to which biopsychosocial factors (e.g., pain duration, depression, education) contribute to interindividual variability in TMO pain and hand disability merits further investigation.

Objectives: This study aimed at 1) describing the pain experience of patients with trapeziometacarpal osteoarthritis (TMO) from a biopsychosocial perspective, and 2) identifying predictors of their pain intensity and hand disability.

Methods: A total of 227 TMO patients recruited from 16 healthcare institutions completed validated questionnaires assessing their biopsychosocial characteristics. The associations of pain severity and hand disability with various biopsychosocial characteristics were analyzed by linear regression.

Results: The participants' mean age was 62.6 ± 8.5 years and 78% were women. Their mean pain intensity on the average in the last seven days was 5.8 ± 2.1 while their hand disability scores averaged 45.4 ± 18.8 on the QuickDASH. In terms of health-related quality of life, the participants' scores on the physical and mental summary scales of the SF-12v2 were 41.0 ± 9.4 and 48.7 ± 9.7 respectively. Results of the multivariable linear regression analyses revealed that age, living condition, pain frequency, pain-related catastrophic thinking, and depression levels accounted for 43.3% of the variance in pain intensity while age, sex, pain intensity, pain-related catastrophic thinking, depression, level of education, employment status and living condition accounted for 60.6% of the variance in hand function.

Conclusion: This comprehensive study showed that patients with TMO experience pain of moderate to severe intensity which can affect various aspects