imunohistochemical study of bone marrow biopsy specimens for the presence of LGLL invasion studies, as well as the study of 4 spleens after splenectomy. SS was diagnosed in 8 out of 18 pts (44.5%) according ACR 2016 criteria. Results: Twelve (66.6%) of 18 pts with RA, neutropenia and splenomegaly were diagnosed with T-LGLL, the patients were divided in 2 groups: FS (6 pts) and RA+T-LGLL (12 pts). Pts with FS debuted with arthritis of small hand joints, extremely rarely with extra-articular manifestations, mainly at a young age (36.5±3.9 years), and developed neutropenia after 10 years of RA. Pts with T-LGLL debuted at a younger age (39.5±4.5 and 51.5±7.8 years, respectively), had a longer course of RA before the development of neutropenia (14.3±3.3 and 5±1.5 years, respectively, p<0.03), and more often had extra-articular manifestations at the onset of the disease. RA activity did not differ between groups and in most cases was characterized by a mild course of articular syndrome. Though the course of RA+T-LGLL group was characterized by low (50%) and moderate (33%) DAS28-CRP activity and active synovitis in only 41.5% of pts, severe joint deformities (stage III and IV) were described in 58.5% of pts. Pts with T-LGLL showed a higher incidence of hepato-splenomegaly (75% and 16.5%, respectively, p=0.02) and more severe neutropenia (p=0.02). The development of severe leukopenia (<1x10^9) and massive hepatosplenomegaly was observed only in pts with T-LGLL, which required splenectomy in 4 cases. SS was more often detected in the FS group than in the RA+T-LGLL group (83.5% and 25%, respectively, p<0.02).

Conclusion: Clinical and laboratory manifestations of FS and T-LGLL are extremely close, therefore, pts who are diagnosed with FS should be examined to exclude T-LGLL.

REFERENCES:

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Objectives: The aim of this study was to determine whether PROs were associated with objective assessment of disease activity.

Methods: We conducted a cross-sectional study including patients with RA (ACR/EULAR 2010). Demographic data were collected. The following PROs were assessed: number of nocturnal awakenings, morning stiffness duration, estimation of spontaneous pain and fatigue by Visual Analog Scale (VAS), and global patient assessment (PGA). In addition, patients rated their current satisfaction with their disease state according to the Austrian school mark system (PATSAT: 1=excellent, 2=good, 3=average, 4=moderate (fair), 5=unsatisfactory). Disease activity was assessed using the 28-joint disease activity score with erythrocyte sedimentation rate (DAS28-ESR) and C reactive protein (DAS28 CRP). We used Cohen's kappa (κ) to determine the agreement between PATSAT and DAS28 ESR.

Results: Seventy-five percent of patients in G1 had received corticosteroids versus 25% in G2 (p=0.01). Patients in G1 had a significantly longer duration of steroid therapy: 17.8 ± 22 versus 13.3 ± 24.3 months (p=0.02). The mean dose of corticosteroids was similar between the two groups: 6.9±4.3 mg/day versus 5.7±4.6 mg/day (p=0.132). The total cumulative dose was significantly higher in G1: 5.6±4.8 mg/day versus 4.8±5.5 mg/day (p=0.025). There was no significant difference in using other DMARDs: Sulphasalazine (p=0.182) and leflunomide (p=0.278). No significant difference was observed with patients under biologic DMARDs: 24.1% in G1 versus 17% in G2 (p=0.725).

Conclusion: Cervical spine involvement is common in RA and may be asymptomatic. Immunopositive patients seem to have more frequently ADD, as well as those with high disease activity and severe structural joint damage. The treatment modalities do not appear to be affected by AAD; however, patients with ADD seem to have higher cumulative doses of corticosteroids and methotrexate. Given the cross-sectional nature of our study, it is difficult to confirm the connection between the two. Further studies are needed.