for the % of work time missed. PtGA scores were higher than PhGA, in each 1272

Bruno Frediani: None declared., Maria Sole Chimenti: None declared., Gero-

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Luisa Costa: None declared., Franco Franceschini: None declared., Francesco

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gene, Janssen, Roche, Antoine Marchesoni; None declared., Giuliana Guggino

AB0489 CORRELATION BETWEEN DISEASE ACTIVITY AND SERUM TNF-ALPHA LEVELS IN PATIENTS WITH ANKYLOSING SPONDYLITIS

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Background: Ankylosing spondylitis (AS) is an immune-mediated rheumatic disease, it belongs to the spectrum of the axial spondyloarthritis. Several elements are important for the pathogenesis of AS - they include interactions in the context of a specific genetic origin between the intestinal microbiome, innate immunity, lymphoid cells and anatomical structures, which are the entheses of the axial skeleton and peripheral joints. The main mediators of the inflammatory process are TNF-α, IL-17 and IL-17A.

Objectives: To study the level of TNF-alpha in the serum of patients with anky-

losing spondylitis and to assess its relationship with the indices of disease activity

before starting therapy with TNF-alpha blockers and in the dynamics after initiation of treatment.

Methods: The present study included 50 patients with ankylosing spondylitis and 31 healthy controls similar in age, sex, and BMI. Clinical and non-clinical methods of examination and evaluation were used for proper assessment and follow-up of patients. The disease activity indices that were used were BASDAI and ASDAS. Statistical analysis was performed with the IBM SPSS program.

v.24., To prove the relationship between the level of TNF-alpha in the serum of patients

and disease activity, a correlation analysis of Spearman Rho was used.

Results: The level of TNF-α in patients with AS was highest before treatment ini-
tiation with biologics, 89.77 ± 36.89 pg / ml, and was significantly higher than that of healthy controls. At the next visit, the TNF-α level decreased to 27.59 ± 23.88 pg / ml, the difference being significant from baseline. 24 months after initiation of treatment with biological therapy average level of TNF-α in patients with AS did not differ reliably from its levels in 6 and 12 month after initiation of treatment, respectively, 22.36 ± 2.38 pg/ml, 19.29 ± 2.07 pg/ml. The level of this cytokine significantly correlates with the activity of the disease, measured by the activity indices BASDAI, ASDAS.

Conclusion: The level of the pro-inflammatory cytokine TNF-alpha is signifi-
cantly higher in patients with ankylosing spondylitis and significantly correlates with the disease activity in them, measured by the respective indices (BASDAI, ASDAS).

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[1] Arends S., N. Lebbink, A. Spoorenberg et al., “The formation of autoantibod-


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AB0490 IMPACT OF SPONDYLOARTHRITIS ON WORK PRODUCTIVITY: A REAL LIFE STUDY

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Background: Work productivity of patients with spondyloarthritis is frequently affected by their disease.

Objectives: We aim to identify disease-related factors associated with poor work productivity in patients with spondyloarthritis.

Methods: A cross-sectional study was performed in patients with spondyloar-

thritis. Data on disease characteristics were collected as well as specific indices: Visual analogue scale (VAS) for fatigue and pain, Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Ankylosing Spondylitis Disease Activity Score with CRP (ASDAS-CRP), Bath Ankylosing Spondylitis Functional Index (BASFI) and Bath Ankylosing Spondylitis Metrology Index (BASMI). EuroQol-5D (EQ5D) was used to assess health-related quality of life. Work productivity was assessed by the Work Productivity and Activity Impairment scale (WPAI). Factors associ-

ated with presenteeism, absenteeism and work productivity loss were evaluated.

Results: One hundred patients were enrolled (73 men and 27 women); mean age was 43.68 ± 10.3 years. Fifty nine percent of patients were employed, 26% were off work and 15% were retired of which 8% were in early retirement. Sixty seven percent of patients had ankylosing spondylitis, 17% had rheumatism associ-

ated with inflammatory bowel disease and 16% had psoriatic rheumatism. The average disease duration was 12.24 ± 8.73 years. Mean age at onset was 33.2 ± 10 years [18-59]. The average diagnostic delay was 2.41 ± 3 years; it was more than five years in 17% of cases. Sacroiliac pain has been noted in 69 patients, lumbar or cervical stiffness in 78 patients and peripheral joint involvement in 18 cases. Thirty one percent of patients had hip joint involvement and 49% had extra-articular manifestation. Fifty percent had inflammatory biological syndrome.

63% were treated with anti-TNFs and 58% needed symptomatic treatment regu-

larly. The mean fatigue and pain VAS was respectively 5.58 ± 2.5 and 5.56 ±

2.9. The mean BASDAI was 4.4 ± 2.4, the mean BASFI was 4.6 ± 2.7 and the

mean ASDAS-CRP was 2.77 ± 1.8. The mean BASMI was 4.4 ± 2.8. The mean
eq 0.006), psorias-

is (p=0.02), inflammatory biological syndrome (p=0.001), need of symptomatic
treatment (p=0.001), fatigue and pain VAS ≥ 4 (p=0.001), BASDAI ≤ 4 (p=0.001), ASDAS-CRP ≥ 2.1 (p=0.001), BASFI ≥ 4 (p=0.001), BASMI ≤ 4 (p=0.002) and low EQ5D score (p=0.001). Work productivity loss was in addition correlated to age at onset < 25 years (p=0.03).

Conclusion: Active disease, reduced physical function and poorer quality of life are associated with reduced work productivity. Early diagnosis and good disease management especially fatigue and pain can potentially improve work outcomes in patients with spondyloarthritis.

Disclosure of Interests: None declared.

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AB0491 THE IMPORTANCE OF MUSCULOSKELETAL SYMPTOM QUESTIONING IN INFLAMMATORY BOWEL DISEASES

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Background: Spondyloarthritis (SpA) occurs in up to 13% of patients with inflammatory bowel disease (IBD) (1). Early diagnosis and treatment of SpA in IBD patients prevents irreversible musculoskeletal diseases.

Objectives: The aim of this study is to emphasize the importance of questioning musculoskeletal symptoms in patients with IBD.

Methods: In the Hacettepe University Gastroenterology Clinic, patients with IBD were questioned for musculoskeletal symptoms between March 2019 and Sep-
tember 2020. For this purpose, a validated DETAIL questionnaire (2) consisting of six questions was asked (1). Have you ever had a finger or a toe and/or another joint that swelling and painful for a different reason? 2. Occasionally, has an entire

finger or toe becomes swollen, making it look like a ‘sausage’? 3. Have you had

pain in your heels? 4. Have you ever had back pain lasting at least 3 months that

was not injury related? 5. Do you have low back pain in the morning and/or after

resting that improves with exercise? 6. Do you wake up at night because of low

pain in your heels? 7. Have you ever had back pain lasting at least 3 months that

was not injury related?

Patients with at least 1 positive out of 6 questions were consulted in the extra-articular clinic, and patients were evaluated for SpA by physical examination, laboratory, and imaging. Demographic and clinical characteristics of IBD patients with and without SpA were compared.
Results: 217 IBD patients were included in the study. Twenty patients with previously known rheumatologic diseases were excluded from the study. 49 (24%) of the remaining 197 patients had a positive answer to at least one question in the DETAIL query. 39 (20%) of these patients were evaluated in the rheumatology clinic, and 16 (8.1%) of them were diagnosed with SpA (spondylitis: 9, peripheral arthritis: 7) (Figure 1). There were no significant differences in terms of age, gender, IBD type, duration of IBD, current treatment, fibromyalgia syndrome (FMS) and depression according to Beck depression inventory between patients with IBD with and without SpA (Table 1).

Table 1. Clinical, demographic characteristics of the IBD patients according to SpA.

<table>
<thead>
<tr>
<th></th>
<th>IBD with SpA</th>
<th>IBD without SpA</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years, median (IQR)</td>
<td>47.03 (27.4)</td>
<td>39.8 (14.1)</td>
<td>0.052</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>8 (50)</td>
<td>17 (74)</td>
<td>0.12</td>
</tr>
<tr>
<td>IBD disease duration, months, median (IQR)</td>
<td>66.7 (70.7)</td>
<td>44.8 (70.0)</td>
<td>0.26</td>
</tr>
<tr>
<td>IBD type, n (%)</td>
<td>6 (37)</td>
<td>11 (48)</td>
<td>0.19</td>
</tr>
<tr>
<td>CD</td>
<td>9 (56)</td>
<td>12 (52)</td>
<td></td>
</tr>
<tr>
<td>UC</td>
<td>1 (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking (ever), n (%)</td>
<td>10 (62.5)</td>
<td>11 (48)</td>
<td>0.37</td>
</tr>
<tr>
<td>HLA-B27 positivity, n (%)</td>
<td>2 (12.5)</td>
<td>1 (4.3)</td>
<td>0.57</td>
</tr>
<tr>
<td>Current medication, n (%)</td>
<td>6 (37.5)</td>
<td>8 (34.8)</td>
<td>0.86</td>
</tr>
<tr>
<td>- Steroid (oral/or topical)</td>
<td>11 (68.7)</td>
<td>14 (61)</td>
<td></td>
</tr>
<tr>
<td>- 5-ASA</td>
<td>6 (37.5)</td>
<td>8 (34.8)</td>
<td>0.86</td>
</tr>
<tr>
<td>- Immunosuppressants (AZA, MTX)</td>
<td>2 (12.5)</td>
<td>4 (17.4)</td>
<td></td>
</tr>
<tr>
<td>- bDMARD</td>
<td>1 (6.7)</td>
<td>3 (13)</td>
<td></td>
</tr>
<tr>
<td>FMS, n (%)</td>
<td>1 (6)</td>
<td>2 (9)</td>
<td></td>
</tr>
<tr>
<td>Beck depression inventory, level of depression, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- minimal</td>
<td>1 (6)</td>
<td>1 (5)</td>
<td>0.13</td>
</tr>
<tr>
<td>- mild</td>
<td>8 (73)</td>
<td>7 (30)</td>
<td></td>
</tr>
<tr>
<td>- moderate</td>
<td>2 (18)</td>
<td>9 (39)</td>
<td></td>
</tr>
<tr>
<td>- severe</td>
<td>0</td>
<td>2 (9)</td>
<td></td>
</tr>
</tbody>
</table>

Harvey-Bradshaw Index for CD disease activity and Mayo score for UC disease activity were used.

SD: standard deviation, IQR: inter-quartile range; IBD: inflammatory bowel disease; SpA: Spondyloarthristis, bDMARD: biological disease modifying anti-rheumatic drug, CD: Crohn’s disease, UC: ulcerative colitis, IC: indeterminate colitis; HBI: Harvey-Bradshaw Index ASA: 5-aminosalicylic acid; AZA: azathioprine; MTX: methotrexate; FMS: Fibromyalgia syndrome

Conclusion: By questioning the musculoskeletal system in IBD patients, 20% of the patients were evaluated in the rheumatology department, and nearly half of these patients (8%) were diagnosed with SpA. The findings point to the importance of musculoskeletal symptom questioning in routine outpatient clinic control in IBD patients.

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Disclosure of Interests: None declared.

Figure 1 Flow chart of IBD patients in the study

Disclosures of Interests: None declared.

Background: When treating people with spondyloarthitis (SA), rheumatologists are focused on reducing disease activity based on activity measurement scores; however, there may be other factors not directly captured by these tools, which impact quality of life.

Objectives: We aim to identify factors associated with poor quality of life in patients with spondyloarthitis.

Methods: A cross-sectional study was performed in 100 patients with spondyloarthitis. Data on sociodemographic and disease characteristics were collected as well as specific scores: Visual analogue scale (VAS) for fatigue and pain, Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Ankylosing Spondylitis Disease Activity Score with CRP (ASDAS-CRP), Bath Ankylosing Spondylitis Functional Index (BASFI) and Bath Ankylosing Spondylitis Metropol Index (BASMI). EuroQol-5D (EQSD) was used to assess health-related quality of life.

Results: A total of 100 Patients were enrolled (73 men and 27 women); the mean age was 43.68 ± 10.3 years. Thirty percent of patients had high level of education (>12 years), 47% had BMI > 25 and 47% were smoking. Sixty seven percent of patients had ankylosing spondylitis, 17% had rheumatism associated with inflammatory bowel disease and 16% had psoriatic rheumatism. The average disease duration was 12.24 ± 8.73 years. Mean age at onset was 33.2 ± 10 years. The average diagnostic delay was 2.41 ± 3 years. Sacroiliac pain has been noted in 69 patients, lumbar or cervical stiffness in 78 patients and peripheral joint involvement in 18 cases. Thirty one percent of patients had hip joint involvement and 49% had extra-articular manifestation. Fifty percent had inflammatory biological syndrome, 63% were treated with anti-TNFα and 58% needed symptomatic treatment regularly. The mean fatigue and pain VAS was respectively 5.58 ± 2.5 and 5.56 ± 2.9. The mean BASDAI was 4.4 ± 2.4, the average BASFI was 4.6 ± 2.7 and the average ASDAS-CRP was 2.77 ± 1.18. The mean BASMI was 4.4 ± 2.8. EQSD questionnaire showed that: 37 patients had moderate anxiety or depression and 12 had extreme anxiety or depression. Good disease management, smoking cessation and encouragement of physical activity can potentially improve patients’ quality of life.

Disclosure of Interests: None declared.

Background: The diagnostic process in a patient with early inflammatory back pain suggestive of axial spondyloarthitis (axSpA) requires assessment and integration of multiple aspects, including clinical examination, biological measurements and radiological assessments. Among the physical examination features, alteration of spinal mobility is often observed in axSpA. However,