Methods: Age- and sex-standardized prevalences were collected from data freely available on the French national health insurance website concerning patients with long-term disability (LTD) #27 (SpA) and #24 (IBD). Data for December 31, 2008 and December 31, 2018 were collected. National data are available by diagnosis coded according to the ICD-10 classification, and data by department only concern all patients benefiting from a given LTD.

Results: National prevalence of SpA is estimated at 0.11% in 2008 (43.8% of women, average age 50 years) and 0.27% in 2018 (54% of women, average age 53 years). National prevalence of IBD is estimated at 0.19% in 2008 (55.6% of women, average age 46 years) and 0.27% in 2018 (55% of women, average age 49 years). Standardized prevalences by pathology are detailed in Table 1. Standardized prevalences by department are shown in Figure 1.

Table 1. Standardized SpA and IBD prevalence (per 100000) by disease in 2008 and 2018.

	Ankylosing Spondylitis	Psoriatic Arthritis	Crohn's Disease	Ulcerative colitis
2008	95	31	103	84
2018	181	57	153	126

Figure 1. Standardized SpA and IBD prevalence by department in 2008 and 2018.

SpA prevalences found in this study are lower than those indicated in the literature: 0.27% versus 0.43% [2]. This may be explained by the fact that not all patients suffering from SpA or IBD benefit from LTD. Moreover, there is a 2.42-fold increase over ten years, which may correspond to the increase in prescription of biotherapies, which requires the benefit of LTD. North-south gradient in the prevalence of IBDs has been found, which is not the case for SpA, which seems to be less prevalent in the north-eastern quarter of the country. These differences in geographical distribution appear to be stable between 2008 and 2018. While IBD and SpA share many physiopathological similarities, their different geographical distributions suggest the importance of different environmental factors in the development of each condition.

Conclusion: The north-south gradient in the distribution of IBD in metropolitan France is not found in SpA. Despite an increasing prevalence, these distributions appear to be stable over time suggesting an important impact of environmental factor in the expression of these close diseases.

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AB0497

IMPACT OF COXITIS ON THE BONE MINERAL DENSITY OF THE HIP IN ANKYLOSING SPONDYLITIS

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Background: Ankylosing spondylitis (AS) is an inflammatory disease, with new bone formation and ossification of the ligamentous apparatus as the primary pathological changes. The osteoporosis is coexisting with new bone formation. It is well known a common complication of this chronic disease. Hip involvement is common in AS [1].

Objectives: The objective of this work is to assess the impact of chronic inflammation of the hip (coxitis) on the bone density at this site.

Methods: This is a cross-sectional study of patients who fulfil the modified New York criteria for AS. These patients had not medical history of osteoporosis or other condition that may affect bone metabolism. Hip involvement was appreciated by physical examination and pelvic x-ray. The functional hip gene was assessed by Lequesne Algofunctional Index (LFI). Bone mineral density at the femoral site was measured using Lunar Prodigy dual-energy X-ray absorptiometry. Osteoporosis is defined when T score is ≤ -2.5 DS (standards deviations). Osteopenia is defined when T score is ≤ -1 DS but more than -2.5 DS. A p value <0.05 was considered significant.

Results: Forty-seven AS patients were collected, 12 women and 35 men with a mean age of 43.8 ± 13.4 years. Smoking was noted in 25% of cases. AS clinical form was axial in 33 cases (70.2%) and mixed (axial and peripheral) in 14 cases (29.8%). The mean duration of AS was 15 ± 10.9 years. Nineteen patients (40.4%) were on DMARD at the time of the study. Coxitis was present in 31 patients (66%). It was bilateral in 13 cases (42.5%). The mean of the LFI was 7.1 ± 6.5 with extremes of 0 to 18. Coxitis form was early in 18 cases (40.9%), synostosis in 15 cases (34.1%) and destructive in 11 cases (25%). Twenty-nine patients (61.7%) had normal femoral bone densitometry, 13 patients (27.7%) had osteopenia and 4 patients (8.5%) had osteoporosis. The mean T-score value at femoral neck site was $-0.5 \text{ SD} \pm 1.303$ [-3 – -2]. Patients with coxitis had a significantly lower T score at the femoral site compared to those without coxitis (-0.77 ± 1.31 DS versus 0.07 ± 1.11 DS respectively with $p = 0.036$).

Conclusion: Our study confirms the role of chronic inflammation in the genesis of bone loss in AS. Given the risks of developing secondary complications as a result of low bone density, early management of AS should be recommended in order to control the inflammatory process and prevent the onset of osteoporosis.

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AB0498

INFLUENCE OF SYNOVITIS OF THE HIP JOINTS ON X-RAY PROGRESSION OF COXITIS IN AXIAL SPONDYLOARTHRITIS. RESULTS OF TWO YEARS FOLLOW-UP

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Background: Almost half of patients with axial spondyloarthritis (axSpA) in Russia have hip joint lesions (HJ), but only in 7% of cases it becomes so severe and requires arthroplasty. The causes and rates of progression of coxitis have not been studied.

Objectives: To assess the relationship between disease activity and the sonographic synovitis of the hip joint with the progression of X-ray coxitis in patients with axSpA with a 2-year follow-up.

Methods: The study included 77 patients (mean age 28 ± 5.92 years) with axSpA (ASAS criteria 2009), who were followed up for at least 2 years. Among them, AS (mNY criteria, 1984) had 66 (86%) patients, and nonradiographic axSpA - 11 (14%). The median duration of the disease was 30 [3–60] months, BASDAI - 4.5 [3.2; 5.9], BASFI - 2.4 [0.9; 4.8]. All patients underwent clinical examination, X-ray and ultrasound investigation of the hip joint during the monitoring period. For ultrasound, coxitis was considered an increase in the cervical-capsular distance (CCD) of more than 7 mm. An increase in BASFI hip by 1 stage in 2 years was considered as progression of radiographic coxitis (PRC).

Results: At the time of enrollment, 66 (86%) patients out of 77 patients had pain in the hip joint, and after 24 months - 48 (62%) ($p > 0.05$). At the time of inclusion, the median pain in the hip joint was 4 [2; 5]; severe pain (≥ 4.0) had 38% of patients. The median CCD at the time of inclusion was 7.3 [6.4; 8.2] mm, and two years later 6.6 [5.9; 8.2] mm ($p > 0.05$). At the sonographic examination at the beginning of follow-up 63 (82.0%) patients had coxitis, and after 2 years - 45 (58%) ($p < 0.05$). X-ray coxitis at the time of inclusion was present in 19 (25%) patients, and after 2 years - in 48 (62%) ($p < 0.05$). Depending on the presence or absence of PRC after 2 years, the patients were divided into 2 groups (Table 1). All patients with PRC at the start of the study had sonographically diagnosed synovitis, while among those without progression, only half of them; relative risk of X-ray progression in the presence of ultrasound of synovitis (RR) = 10.5 (p

<0.05). The groups did not differ in terms of activity indicators and the presence of extra-axial manifestations.

Table 1. Characteristics of patients with axSpA at the time of inclusion in the study who had PRC after 24 months of observation.

Parameters	ΔBASRI hip=0 n=33	ΔBASRI hip >0 n = 44	p
Sex (m/w), n	22/11	32/12	>0,05
The duration of the disease, m., Me [25;75%]	36 [19;132]	48 [24;84]	>0,05
Age, years, Me [25;75 %]	30 [26;34]	28 [24;34]	>0,05
BASDAI, Me [25;75 %]	4,3 [3,1;5,8]	4,7 [3,8;6,3]	>0,05
BASFI, Me [25;75 %]	3,4 [0,6;5,6]	2,1 [1,1;4,2]	>0,05
ASDAS (SRP), Me [25;75 %]	2,6 [1,6;3,9]	3,2 [2,3;4,2]	>0,05
ESR, mm/h, Me [25;75 %]	15 [7;30]	23,0 [12;35]	>0,05
SRP, mg/l, Me [25;75 %]	12,8 [1,8;31,0]	17,8 [5,6; 50,3]	>0,05
Peripheral arthritis, n %	26 (79%)	32 (73%)	>0,05
US synovitis n%	19 (58%)	44 (100%)	<0,05*
Pain in HJ n%	28 (85%)	38 (86%)	>0,05

Conclusion: X-ray progression of coxitis is associated with ultrasound synovitis and does not depend on the activity of the disease.

Disclosure of Interests: None declared.

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AB0499

PHYSICAL ACTIVITY ASSESSMENT IN TUNISIAN PATIENTS WITH SPONDYLOARTHRITIS: THE IPAQ EVALUATION

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Background: The occurrence of Spondyloarthritis (SpA) often conditions patients' quality of life and hinders their well-being. Physical activity (PA) is associated with various health-related benefits among adults with chronic inflammatory rheumatism but may be insufficiently performed.

Objectives: This study aimed to assess PA in patients with SpA and explore its associated factors.

Methods: This is a single-center cross-sectional study, involving patients with SpA, visiting our outpatient hospital over eight weeks. Patients responded to the International Physical Activity Questionnaire-Short form (IPAQ-S).

Results: Sixty patients were included (39M/21 F) with an average age of 45.8 years [25-78]. The mean duration of SpA was 13.2 years [1-25]. About 80% of patients were from an urban setting. Sixty-three percent of patients had a professional activity, while 13.3% were retired. Twenty-nine patients (48.3%) had axial and peripheral form, 18 patients (30%) had SpA with enteropathic arthritis, 8 (13.3%) with psoriatic arthritis, 3 patients (5%) had axial spondyloarthritis, and only 2 patients (3.3%) with SAPHO-Syndrom. About 23% of patients had hip arthritis and only 5% had uveitis. Fifty-eight patients were on TNF-inhibitor (21/58 Adalimumab, 15/58 Infliximab, 14/58 Etanercept, 8/58 Golimumab). The average BASDAI was 2.7/10. The average ASDAS_{CRP} was 2.1/10. The average BASFI was 3.3/10. IPAQ results were distributed as follows: 78.3% of patients were in the « low physical activity » category, 21.7% were in the « moderate physical activity » while none of the patients were in the « high physical activity ». Patients without employment had lower levels of physical activity (29.7%) but no association was observed between those two items (p=0.082). Disease activity objectified with BASDAI was related to low physical activity (p=0.045) whereas no association was observed with ASDAS_{CRP} (p=0.870) or BASFI (p=0.056). Otherwise, TNF-inhibitor treatment was not related to different levels of PA (p=0.09).

Conclusion: Tunisian patients with SpA don't perform enough physical activity. Except for high disease activity, the different levels of PA did not appear to be explained by other disease-related variables. Thereby, physical activity should be encouraged in SpA.

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AB0500

IMPACT OF COVID-19 PANDEMIC IN OVERALL HEALTH AND FUNCTIONING IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS: RESULTS FROM THE REUMAVID STUDY (PHASE 1)

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Background: Evidence on the impact of the COVID-19 pandemic on the overall health and functioning in patients with axial spondyloarthritis (axSpA) is scarce.

Objectives: To analyse the impact of the COVID-19 pandemic on the overall health and functioning in patients with axSpA.

Methods: Data from axSpA patients participating in the first phase of the REUMAVID study were analysed. REUMAVID is a cross-sectional, observational study collecting data through an online questionnaire of unselected patients with rheumatic and musculoskeletal diseases (RMDs), recruited by patient organizations. The survey was disseminated during the beginning of the COVID-19 pandemic (April-July 2020) in seven European countries (Cyprus, France, Greece, Italy, Portugal, Spain, and the United Kingdom). Patients with axSpA who completed the ASAS health index (ASAS-HI) questionnaire were included in this analysis. Descriptive analyses were used to present socio-demographic and clinical characteristics, as well as daily habits. Overall health and functioning were defined according to the ASAS-HI (0-17), as follows: good health (ASAS-HI ≤5), acceptable health (ASAS-HI 6-11), and poor health (ASAS-HI ≥12). As secondary outcomes, well-being (WHO-5), self-perceived health status, and HADS for anxiety and depression were assessed.

Results: Out of 670 axSpA patients, 587 (87.6%) completed ASAS-HI. Of these, 70.4% were female, 72.6% were married or in a relationship, 46.7% had university studies and 37.6% were currently employed. Mean age was 49.9±12.8 years and mean BMI was 26.7±5.5. Regarding extraarticular manifestations, 13.6% had psoriasis, 12.1% inflammatory bowel disease and 18.7% uveitis. Before the COVID-19 pandemic, 50.9% were receiving biological drugs, 46.3% NSAIDs, 26.4% painkillers, 24.7% conventional DMARDs, and 11.9% oral corticosteroids. According to the ASAS-HI, 19.6 % of patients were classified as having poor health, with the most affected aspects being pain (92.0%), movement (86.5%), maintenance of body position (80.6%), energy (79.0%) and sleep (75.3%). Regarding self-perceived health status, 14% reported their health status as "bad" or "very bad", and 46.8% reported worsening health during the pandemic (Table 1). A distribution of the results of the total ASAS-HI scores can be seen in Figure 1.

Table 1. Overall health and well-being, disease activity, and mental health.

Primary Outcome (ASAS-HI)	Mean ± SD or n (%)
ASAS-HI (0-17), n=587	8.0 (±3.9)
ASAS-HI	
<5 (good health)	159 (27.1)
5-12 (acceptable health)	313 (53.3)
≥12 (poor health)	115 (19.6)
Secondary Outcomes	
WHO-5	
WHO-5 (0-100), n=584	46.3 (±23.1)
WHO-5 Poor wellbeing WHO-5 ≤50	330 (56.5)
Self-perceived health status, n=585	
Very good	33 (5.6)
Good	214 (36.6)
Fair	256 (43.8)
Bad	69 (11.8)
Very bad	13 (2.2)
Change in health status during lockdown, n=587	
Much worse than before	54 (9.2)
Moderately worse	220 (37.6)
Same as before	270 (46.0)
Moderately better	35 (6.0)
Much better than before	6 (1.0)
HADS	
HADS Anxiety (0-21), n=587	8.4 (±4.1)
HADS Anxiety	
No case (0-7)	248 (42.7)
Borderline case (8-10)	151 (26.0)
Case (11-21)	182 (31.3)
HADS Depression (0-21), n=587	7.0 (±4.3)
HADS Depression	
No case (0-7)	329 (56.6)
Borderline case (8-10)	134 (23.1)
Case (11-21)	118 (20.3)