

**Table 1. Age-matched comparisons across diagnoses**

	Gout	PsA	RA	AS	p-value	p-value	p-value	p-value	p-value	p-value
	Gout	Gout vs PsA	Gout vs RA	Gout vs AS	Gout vs PsA vs RA	Gout vs PsA vs AS	Gout vs RA vs AS	Gout vs PsA vs RA vs AS	Gout vs PsA vs RA vs AS	Gout vs PsA vs RA vs AS
Total (n)	249	249	249	249	N/A					
Age, mean (SD)	62.5 (11.2)	64.2 (10.2)	63.1 (11.6)	62.8 (10.5)	NS					
Education ≤12 years, n (%)	132 (53.0)	148 (59.4)	160 (64.3)	139 (55.8)	NS					
HAQ, mean (SD)	0.19 (0.40)	0.48 (0.55)	0.60 (0.63)	0.58 (0.58)	***	***	***	***	NS	NS
VAS General Health, mean (SD)	2.6 (2.3)	3.7 (2.4)	3.8 (2.6)	4.0 (2.3)	***	***	***	***	NS	NS
VAS Pain, mean (SD)	2.6 (2.4)	4.0 (2.6)	3.8 (2.6)	4.2 (2.4)	***	***	***	***	NS	NS
VAS Fatigue, mean (SD)	3.6 (2.6)	4.5 (2.7)	4.3 (2.6)	4.9 (2.5)	***	***	*	***	NS	*
<b>SF-36 domains, median (IQR)</b>										
Physical function	90.0 (75.0-95.0)	70.0 (51.3-95.0)	70.0 (45.0-90.0)	75.0 (50.0-90.0)	***	***	***	***	NS	NS
Role physical	100.0 (33.3-100.0)	50.0 (0.0-100.0)	50.0 (0.0-100.0)	50.0 (0.0-100.0)	***	***	***	***	NS	NS
Bodily pain	72.0 (42.0-100.0)	52.0 (41.0-74.0)	52.0 (41.0-74.0)	52.0 (41.0-64.0)	***	***	***	***	NS	NS
General Health	67.0 (47.8-80.8)	56.0 (35.0-72.0)	55.0 (37.0-71.0)	50.0 (35.0-71.0)	***	***	***	***	NS	NS
Vitality	65.0 (50.0-77.5)	57.5 (37.5-75.0)	57.5 (42.5-72.5)	50.0 (32.5-70.0)	***	*	*	***	NS	NS
Social function	100.0 (68.8-100.0)	81.3 (57.8-100.0)	81.3 (67.2-100.0)	81.3 (50.0-100.0)	***	**	**	***	NS	NS
Role emotional	100.0 (66.7-100.0)	100.0 (33.3-100.0)	100.0 (33.3-100.0)	100.0 (33.3-100.0)	**	NS	**	**	NS	NS
Mental health	82.0 (66.0-92.0)	78.0 (60.0-92.0)	78.0 (60.0-88.0)	73.0 (60.0-88.0)	**	NS	*	**	NS	NS
<b>SF-36 summary scores, median (IQR)</b>										
Physical component score	48.4 (38.8-54.7)	40.2 (28.5-50.2)	40.2 (28.2-49.0)	38.7 (30.1-48.2)	***	***	***	***	NS	NS
Mental component score	51.7 (43.7-56.5)	51.0 (39.2-56.4)	50.7 (39.6-56.3)	47.7 (37.1-55.3)	*	NS	NS	*	NS	NS

HAQ=Health Assessment questionnaire; IQR=Interquartile range; SD=Standard deviation; VAS=Visual Analogue Scale; NS=non-significant; \* = significant at  $p < 0.05$ ; \*\* = significant at  $p < 0.01$ ; \*\*\* = significant at  $p < 0.001$

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AB0634

### BELIEFS ABOUT URATE LOWERING THERAPY DIFFER BETWEEN GENERAL PRACTITIONERS AND RHEUMATOLOGISTS

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**Background:** Uric acid lowering therapy (ULT) can be effective in gout if taken correctly (1), but non-adherence is a known problem (2). Although patients' adherence barriers regarding ULT, such as lack of knowledge on disease and therapy, and beliefs, have been widely studied (3), less is known physicians' beliefs.

**Objectives:** To investigate the physicians' beliefs on ULT treatment in both primary and secondary care in the Netherlands.

**Methods:** Cross-sectional study among all rheumatologists of the Sint Maartenskliniek and to all General Practitioners (GPs) of 17 practices, participating in the practice-based research network Family Medicine Network Nijmegen,

Netherlands. All participants filled out the beliefs about medication questionnaire (BMQ), adjusted for physicians; in addition data were collected on physician characteristics including working experience in total and gout consultations. The BMQ consists of two parts, a specific part with 10 questions about beliefs on necessity (N=5) and concerns (N=5) regarding ULT and a general part with 8 questions about beliefs on harms (N=4) and overuse (N=4) regarding medication in general. Each question is scored on a Likert-scale from 1-5, a higher score corresponds to higher beliefs on that category. Sum scores for all four categories were calculated. With the total scores on the specific BMQ including necessity and concerns beliefs, physicians were classified in four different categories (Table 1)(4).

**Results:** In total 112 physicians received the questionnaire, 28 of 37 rheumatologists (76%) and 45 of 75 GPs (60%) responded. Rheumatologists had less years of experience than GPs (median 8.5 years (IQR 3 – 14) versus (vs) 13 years (IQR 8-20)) and less hours of patient contact per week (15 hours (IQR 8.5 – 20) vs 24 hours (IQR 20 – 30)). Rheumatologists reported more consultations for gout per week than GPs: median 4 (IQR 1 – 6.6) vs 1 (IQR 0.2– 1).

Rheumatologists scored higher on the BMQ necessity scale, 17.5 (95% CI 16.6 – 18.5) compared to GPs 16.1 (95% CI 15.1 – 17.1). GPs scored higher on BMQ concern scale, 12.1 (95% CI 11.4 – 12.7) compared to rheumatologists, 10.4 (95% CI 9.7 – 11.2). On medication in general, GPs scored higher on both overuse and harms scales compared to rheumatologists, 11.3 (95% CI 10.7 – 12) versus 9.9 (95% CI 9 – 10.7) and 8.3 (95% CI 7.9 – 8.7) vs 7.1 (95% CI 6.5 – 7.7), respectively. Table 1 shows classification according to the BMQ specific for both groups.

**Table 1. Classification based on the adapted BMQ**

	Rheumatologists (N=28)	GPs (N=45)
Acceptant (%)	19 (67.9)	16 (35.6)
Ambivalent (%)	0	8 (17.8)
Sceptic (%)	1 (3.6)	5 (11.1)
Indifferent (%)	8 (28.6)	16 (35.6)

**Conclusion:** For the majority of rheumatologist the necessity beliefs outweighs concern beliefs towards the use of ULT outweighs concern beliefs. GPs show a more heterogenic profile, including acceptant, indifferent and ambivalent beliefs towards ULT use. GPs also show higher harm and overuse concerns regarding medication in general. Next step is to investigate possible associations with actual ULT use and disease outcome.

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AB0635

### EVALUATION OF THE INTIMA-MEDIA THICKNESS INDEX BY CAROTID DOPPLER IN PATIENTS WITH MONOSODIUM URATE DEPOSITION ARTHRITIS OF THE HOSPITAL DOCENTE PADRE BILLINI, DOMINICAN REPUBLIC

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**Background:** Hyperuricemia and gout are risk factors for atherosclerosis subclinical and cardiovascular complications. (1) However, it is still debated whether uric acid is an independent predictor of cardiovascular risk. (2) Vascular Doppler and in particular the measurement of the intima-media thickness and the detection of plaques are useful in the evaluation of cerebrovascular disease and cardiovascular risk. (3) An intima-media thickness greater than 0.9mm and / or the presence of atheromatous plaques in the carotid are predictive of high cardiovascular risk and silent heart disease. (4) Gouty arthritis has been associated with alteration of the carotid intima media thickness (cIMT) and subclinical atherosclerosis. Cukurova et al studied patients with gout, finding an increase in cIMT compared to patients with asymptomatic hyperuricemia. (5)

**Objectives:** Assess the carotid intima-media thickness in patients with monosodium urate deposits arthritis