Results: There were 93 patients, 47 with radiographic sacroiliitis (RSPA) and 46 patients without but all - these 46 - had magnetic sacroiliitis. This population is Afro-Caribbean for 98%. Mean age at onset of clinical signs is 38.5 ± 15.0 years and median age is 37.0 (13-77). An evocative family history is noted in 37%. All these 93 patients suffer from rachialgia.

But the axial complaint is often secondary to the peripheral involvement. 3 patients have a mechanical spinal complaint. All the others have intermittent inflammatory complaint evolving by flares affecting all the spinal stages. 15/93 patients have isolated axial complain without peripheral disease. Enthesopathies are seen in 70%.

Peripheral inflammatory joint complain is observed in 78 patients (84%), it is a bilateral and symmetrical chronic polyarticular pattern affecting (70/78) the small joints of the hands, forefeet and wrists. Ankle bi-arthritis is almost systematic and is observed in 71/78 patients; 8 patients with RSPA had no polyarthritis but oligo (6) or monoarthritis (2). Peripheral inflammatory joint is more frequent in NRSPA than in RSPA (98% vs 70%). Ultrasound individualises grade II synovitis (78/78), rarely with a Doppler effect (5/78). On average, more painful and swollen joints are observed in NRSPA than in RSPA. Extra articular and immunological aspects and activity scores are in table 1.

Good sensitivity of peripheral arthritis to NSAIDs and MTX is noted in 94 and 91%.

Conclusion: NRSPA are not uncommon in the Afro-Caribbean population, but are distinct from Caucasian SpA by several points: female predominance, rarity of B27 and syndesmophytes, frequency of polyalgic pattern, frequency of peripheral arthritis, rarity of extra-articular manifestations, more frequent but less marked inflammation, good response of arthritis to NSAIDs and MTX. Appropriate classification criteria for Afro-descendant populations is an urgent unmet need.

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Table 1. Extra articular manifestations, activity scores and immunological aspects of the patients.

Item	Results (%) NRSPA n=46	Results (%) RSPA n=47
Dactylitis	11 (23 %)	13 (27 %)
Uvéitis	5 (11 %) (p 0.02)	15 (32%)
Psoriasis	1 (2 %)	1 (2 %)
IBD	4 (9 %) (p 0.02)	10 (21 %)
Balanitis	0	0
Non gonococcal urethritis	0	0
Non gonococcal cervicitis	0	0
High CRP (at least 2 measure)	21 (45%) (p 0.03)	30 (63%)
Mean CRP mg/l	6 ± 4	17 ± 7
BASDAI	4.1 ± 0.2	4 ± 0.2
EVA pain	4.5 ± 0.4	4.5 ± 0.2
HAQ	0.6 ± 0.3	0.5 ± 0.2
EVA Global	4.9 ± 0.8	4.8 ± 0.8
EVA Spine	5 ± 0.5	4.1 ± 0.9
FIRST score >5	5 / 46 patients (10.9%)	6 / 47 patients (12.5%)
HLA B27 presence	4/46 (8.7%) (p 0.01)	14/47 (29.8%)
Sexe	male 10 (21.3%) (p 0.001)	male 19 (51.3%)
ACPA	0	0
Latex Waaler-Rose	1 (low titer, > 65 years)	1 (low titer, > 65 years)
ANA	2 (low titer, < 1/320°)	3 (low titer, < 1/320°)

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POS0946

DISTRIBUTION OF COMORBIDITIES IN SPONDYLOARTHRITIS WITH REGARD TO THE PHENOTYPE AND THE PRESENCE OF PSORIASIS: DATA FROM THE ASAS-COMOSPA STUDY

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Background: Comorbidities have been reported to be more prevalent in patients with Spondyloarthritis (SpA) compared to the general population. Previous studies have suggested that patients with peripheral phenotypes exhibit a higher prevalence of traditional cardiovascular risk (CV) factors compared to those with a predominantly axial phenotype. However, the role of psoriasis in such differences has not been deeply studied.

Objectives: To compare the prevalence of comorbidities (CV, malignancies and osteoporosis (vertebral or peripheral fracture, or low bone mineral density)) between patients with axial and peripheral phenotypes and to evaluate the role of psoriasis in such comorbidities in the whole spectrum of SpA (including psoriatic arthritis).

Methods: Patients from the cross-sectional ASAS-COMOSPA study were classified as having either axial (presence of sacroiliitis on x-ray or MRI) or peripheral phenotype (absence of sacroiliitis AND presence of arthritis, enthesitis or dactylitis). Patients with each phenotype were divided into two groups depending on the presence or history of psoriasis. Pair-wise comparisons among the four groups (axial and peripheral with psoriasis/without psoriasis phenotypes) were conducted through univariate logistic regressions and generalized linear mixed models using disease duration and country as fixed and random effects, respectively. Multivariate analysis using were used to evaluate whether psoriasis and the phenotype are independently associated with each comorbidity.

Results: A total of 3291 patients were included in this analysis (mean age 43.6 years, 65% males). The peripheral phenotype with psoriasis showed the highest prevalence of hypertension (44.9%), dyslipidaemia (34%) and diabetes (8.8%), while axial phenotype without psoriasis exhibited the lowest prevalence of dyslipidaemia (14.2%), diabetes (4.1%) and stroke (0.9%) (Table 1). Among patients with psoriasis, the axial phenotype showed a significantly [OR, 95%CI] lower prevalence of hypertension [OR 0.5, 0.4-0.8] and lower Framingham score [OR 0.97, 0.95-0.99] compared to peripheral patients even after adjusting for disease duration and country. Among patients with axial phenotype, patients with psoriasis showed higher prevalence of hypertension [OR 1.8, 1.4-2.2], dyslipidaemia [OR 2.0, 1.7-2.5], diabetes [OR 2.1, 1.4-3.0] and Framingham score [OR 1.0, 1.0-1.1] than non-psoriatic patients. Multivariate analysis confirmed that hypertension, dyslipidaemia and the Framingham score are independently associated with both the psoriasis and the peripheral phenotype.

Prostatic cancer and colon cancer were independently associated with the presence of psoriasis but not with the phenotype. No differences were found across groups concerning osteoporosis.

Conclusion: Both a peripheral phenotype and the presence of psoriasis were independently associated with an increased CV risk. Psoriasis seems to be associated with a higher prevalence of some malignant diseases, while osteoporosis do not seem to be associated with either phenotype or the presence of cutaneous involvement.

Table 1. Description of comorbidities across the four groups.

	Psoriatic axial N = 460 n (%)	Non-psoriatic axial N = 2541 n (%)	Psoriatic peripheral N = 147 n (%)	Non-psoriatic peripheral N = 136 n (%)	p-value*
BMI, mean (SD)	27.4 (5.5)	25.5 (5.5)	27.3 (5.7)	26.6 (5.3)	<0.001
Hypertension	135 (29.5)	487 (19.2)	66 (44.9)	25 (18.4)	<0.001
Dyslipidemia	113 (24.8)	359 (14.2)	50 (34)	23 (17)	<0.001
Diabetes	37 (8.1)	104 (4.1)	13 (8.8)	7 (5.2)	<0.001
Ischemic heart disease	16 (3.5)	51 (2)	5 (3.4)	2 (1.5)	0.162
Stroke	11 (2.4)	22 (0.9)	3 (2)	2 (1.5)	0.028
Framingham score, mean (SD)	9.6 (8.7)	6.6 (7.5)	11.8 (8.8)	5.8 (6)	<0.001
Prostatic cancer	5 (1.8)	5 (0.3)	0 (0)	0 (0)	0.006
Breast cancer	1 (7)	3 (0.4)	1 (1.4)	0 (0)	0.181
Colon cancer	4 (0.9)	4 (0.2)	1 (0.7)	1 (0.7)	0.046
Basal cell carcinoma	6 (1.3)	9 (0.4)	1 (0.7)	4 (3)	<0.001
Lymphoma	0 (0)	4 (0.2)	3 (2)	0 (0)	<0.001

*ANOVA or chi-square for continuous and qualitative variables, respectively.

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POS0947

PSORIATIC ARTHRITIS WITH HYPERURICEMIA: MORE PERIPHERAL, DESTRUCTIVE AND CHALLENGING TO TREAT

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Background: Gout and psoriatic arthritis (PsA) can co-exist in the same patient. These 2 diseases seem strongly linked, but the pathophysiological mechanisms of this link have not yet been defined. Hyperuricemia could be an important determinant of PsA¹.

Objectives: To study the impact of hyperuricemia on clinical presentation, severity and associated comorbidities of PsA.

Methods: We conducted a retrospective bicenter case-control study in Strasbourg and Colmar, France. Patients with PsA (according to "L40.5 arthropathic psoriasis" ICD-10 coding) and at least one available serum urate level measurement, were included from 2009 to 2019. Demographic, comorbidities, clinical and radiographic data were collected. Hyperuricemia was defined as serum urate level $\geq 360 \mu\text{mol/L}$. We defined "good responders to ongoing PsA treatment" as patients with no outbreak of PsA, biological inflammatory syndrome and therapeutic modification at the last follow-up. Patients with "destructive" disease had one or more erosion(s) seen on standard X-ray, ultrasonography, MRI or TDM.

Results: We included 242 patients. 73 (30.2%) had hyperuricemia and 15 (6.2%) met criteria for gout. On univariate analysis, as compared with normo-uricemic patients, hyperuricemic patients were more often male (72.6% vs. 39.1%, $p = 1.6 \times 10^{-6}$), had higher BMI (30.9 vs. 28.7 kg/m^2 , $p = 0.015$) and had more comorbidities (Charlson Comorbidity Index: 2.6 vs. 1.8, $p = 0.005$). In hyperuricemic versus normo-uricemic patients, PsA started at an older age (47.5 vs 43 years, $p = 0.016$); PsA was more polyarticular (56.2% vs 41.9%, $p = 0.049$) than axial (9.6% vs 22.8%, $p = 0.019$) and more destructive (52.8% vs. 37.4%, $p = 0.032$). Median uricemia was higher in patients with destructive than non-destructive PsA (321 vs $288.8 \mu\text{mol/L}$, $p = 0.0038$), and hyperuricemia was more frequent with than without joint destruction (37.6% vs 25.8%, $p = 0.047$). The multivariate analysis confirmed hyperuricemia associated with peripheral joint involvement (OR 2.98, $p = 0.025$) and less good response to PsA treatment (OR 0.35, $p = 0.024$).

Figure 1. Description of normo- and hyperuricemic psoriatic arthritis

CRF: moderate to severe chronic renal failure. MACEs: major adverse cardiovascular events. HBP: high blood pressure. MetS: metabolic syndrome. PsA: psoriatic arthritis

Conclusion: Patients with hyperuricemic PsA have less good response to PsA treatment than those with normo-uricemia and more peripheral and destructive joint damage. Recognition of PsA in which hyperuricemia would play an aggravating role could modify the management. This would justify a diagnostic reassessment in case of doubt, the possible introduction of hypouricemic treatment and the careful use of NSAIDs in the context of multiple morbidities.

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POS0948

HYPERKYPHOSIS IN AXIAL SPONDYLOARTHRITIS: FACTORS THAT PRODUCE ITS APPEARANCE AND EFFECT ON MOBILITY AND FUNCTION

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Background: Hyperkyphosis (HK) is a characteristic sign in patients with a large level of axial spondyloarthritis (axSpA) involvement. Kyphosis is defined as a sagittal deviation in the spinal alignment. Kyphosis can be graded in severity by the Cobb angle. The occiput-wall distance (OWD) is a surrogate measure of kyphosis. When this distance is greater than 0 cm, it is because the patient has an advanced affection level that produces a reduction of physical function and other comorbidities. It is important that HK does not appear in the patient.

Objectives: To analyze contributors and effects of HK in patients with axSpA.

Methods: Nonparametric preprocessing for parametric causal inference was used for selection of two matched groups, formed by 42 axSpA patients each one, from the CASTRO cohort with similar covariate distributions (age and sex). Outcomes analyzed, besides OWD, included activity (BASDAI, ASDAS), physical function (BASFI) and mobility (BASMI). An inertial sensor-based system (ViMove) was used to analyze cervical and lumbar mobility and to calculate the UCOASMI index[1]. Structural damage was assessed according the mSASSS and its components (cervical and lumbar).

Results: Mean (sd) values of the different variables for each group are shown in table 1. Significant differences according to an independent t-test (p), variation coefficient (V.C.), effect size (E.S.) and correlation with OWD (Pearson r), are also included in this table.

	OWD=0 (n=42)	OWD>0 (n=42)	P	V.C.	E.S.	r
Age (y)	47.6 (8.9)	48.7 (8.7)	N.S.	2%	0.13	0.2
Sex (female %)	12%	14%	N.S.	-	-	-
B27 (positive %)	87%	86%	N.S.	-	-	-
Disease duration (y)	19.7 (11.4)	24.9 (13.4)	*	26%	0.42	0.30**
Diagnostic delay (y)	6.4 (9.6)	6.6 (8.4)	N.S.	2%	0.01	-0.09
BMI (kg/m ²)	25.8 (3.1)	29.5 (4.6)	**	14%	0.94¥	0.39***
ASDAS	2.2 (1.0)	2.7 (1.0)	*	21%	0.43	0.08
BASDAI	3.6 (2.4)	4.1 (2.5)	N.S.	6%	0.17	-0.02
mSASSS	10.6 (6.9)	22.6 (19.2)	***	113%	0.92¥	0.75***
Cervical mSASSS	5.4 (4.4)	11.2 (11.2)	***	106%	0.74	0.69***
Lumbar mSASSS	5.1 (3.6)	11.3 (10.0)	***	121%	0.91¥	0.67***
BASFI	2.6 (2.51)	4.6 (2.8)	***	74%	0.74	0.26*
BASMI	2.4 (1.1)	4.2 (1.5)	***	77%	1.40	0.77***
UCOASMI	3.7 (1.0)	5.6 (1.4)	***	51%	1.53	0.77***
Cervical flexion (°)	101 (20)	74 (29)	***	-26%	-1.07	-0.71***
Cervical rotation(°)	133 (20)	103 (37)	***	-23%	-1.04	-0.68***
Cervical lat. flex.(°)	67 (21)	44 (24)	***	-33%	-0.96¥	-0.64***

Sign.: *p<0.05, **p<0.01, *** p<0.001. ¥: Large effect size (ES>0.8)

There were not significant differences in age, sex as expected. HK group patients started earlier (5.2 years). The percentage of HLAB27+ is similar, so this antigen has not a relationship with HK. BMI is greater in HK group (14%); this can be a factor for HK appearance or a consequence of HK (less physical activity). Activity (according ASDAS) was slightly higher in HK. There were very significant differences in structural damage, and HK appears to be equally affected by damage at cervical and lumbar regions. BASFI also shown a significant reduction in HK. There was great reduction of mobility according to mobility indexes and cervical range of movement (23%-33%). In a multivariate regression analysis using all variables of the table and OWD as dependent variable, only mSASSS and BMI were included in the final model (adj. $r^2 = 0.61$). In a ROC analysis, mSASSS shown to and acceptable variable to distinguish between groups (AUC=0.70, cutoff=13). ASDAS