years. The mean disease duration was 12.65 ± 9.49 years. The clinical presentation of SpA was peripheral in 61 cases and axial in 118 cases. The mean disease scores activity was: BASDAI: 3.94 ± 2.046 and ASDASCRP: 2.75 ± 1.05 . The mean BASFI was 4.17 ± 2.7 .

SP changes were observed in 31 patients: score 1 (n=14), score 2 (n=8), score 3 (n=8) and score 4 (n=4). Sex ratios M/F were 2.1 and 1.65 in G1 and G0, respectively (p=0.23). No statistically significant differences were reported between the two groups G0 and G1: mean age (40.48 vs. 43.45, p=0.324), mean disease duration (11.19 vs. 14.45, p=0.218), mean BASDAI (3.8 versus 3.9, p=0.850), mean ASDAS-ESR (3.09 vs. 2.55, p=0.113) and mean BASFI (3.76 versus 4.96, p=0.06) respectively. In G1, nine patients had hip involvement (p=0.203). Enthesitis was more common in patients with SP changes (p=0.02).

Conclusion: In our study, the presence of enthesitis was associated with SP changes. Surprisingly, age and disease duration did not influence SP changes (1).

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Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.4013

POS1014

CENTRAL SENSITIZATION HAS MAJOR IMPACT ON QUALITY OF LIFE IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Maintaining optimal health-related quality of life (QoL) is the ultimate goal of treatment in axial spondyloarthritis (axSpA). Chronic pain has a large potential impact on QoL. Central sensitization (CS) may explain part of the chronic pain in axSpA. However, the role of central sensitization (CS) herein has only been studied to a limited degree and current axSpA guidelines pay little attention to identification and treatment of CS.

Objectives: To explore the relationship between CS and QoL in axSpA.

Methods: Consecutive outpatients with axSpA from the Groningen Leeuwarden Axial Spondyloarthritis (GLAS) cohort were included. CS was assessed with the Central Sensitization Inventory (CSI; 0-100), QoL with the AS Quality of Life questionnaire (ASQoL; 0-18) and disease activity with the AS Disease Activity Score (ASDAS_{CRP}). A high probability of CS was defined as CSI score ≥ 40 and active disease as ASDAS_{CRP} score ≥ 2.1 . Patient characteristics and clinical assessments were compared between groups with CSI score <40 and ≥ 40 . (1) Multivariable regression analysis was conducted to investigate the relationship between CSI and ASQoL scores, correcting for potential confounders.

Results: Of the 178 axSpA patients with available CSI score, 149 completed the ASQoL. Mean age of the 178 included patients was 47.4 ± 14.1 years, 78 (44%) were female, mean symptom duration was 21.4 ± 13.6 years and 88 (52%) were using bDMARDs. Mean CSI score was 38.0 ± 14.1 , mean ASQoL 6.0 ± 5.3 and mean ASDAS_{CRP} 2.1 ± 1.0 . CSI score ≥ 40 was significantly associated with higher mean ASQoL (9.7 vs. 3.3), higher mean ASDAS_{CRP} (2.6 vs. 1.7), female gender (60% vs. 29%) and more often enthesal involvement (61% vs. 26%) (Table 1).

Table 1. Selection of patient characteristics, disease activity and clinical outcome variables for patients with axSpA, divided in subgroups for CSI score with a cutoff point of 40.

Characteristics	All patients n = 178	CSI<40 n = 98 (55%)	CSI ≥ 40 n = 80 (45%)
Age (years)	47.4 $\pm$ 14.1	48.7 $\pm$ 15.0	45.8 $\pm$ 12.7
Female	78 (44)	27 (29)	44 (60)*
Symptom duration (years)	21.4 $\pm$ 13.6	21.5 $\pm$ 13.5	21.2 $\pm$ 13.8
HLA-B27+	133 (79)	70 (79)	54 (79)
Smoker	45 (27)	28 (32)	15 (23)
BMI (kg/m ²)	26.7 $\pm$ 5.0	26.2 $\pm$ 4.4	27.5 $\pm$ 5.8
Completed higher education ¹	81 (71)	48 (70)	34 (76)
Biological use	88 (52)	49 (52)	39 (51)
RDCI (0-9)	0.0 (0.0 – 1.0)	0.0 (0.0 – 1.0)	0.0 (0.0 – 1.8)
Peripheral arthritis ²	10 (6)	5 (6)	5 (8)
Enthesal involvement ³	64 (40)	23 (26)	38 (61)*
ASDAS _{CRP}	2.1 $\pm$ 1.0	1.7 $\pm$ 0.9	2.6 $\pm$ 1.0*
CRP (mg/ml)	2.9 (1.1 – 6.8)	2.6 (1.1-6.0)	3.6 (1.4 – 7.0)
ASQoL (0-18)	6.0 $\pm$ 5.3	3.3 $\pm$ 3.6	9.7 $\pm$ 4.9*
CSI (0-100)	38.0 $\pm$ 14.1	28.0 (23 – 34)	50.0 (43.0 – 56.0) ^{NA}

Values are n (%), mean $\pm$ SD or median (IQR).¹International Standard Classification of Education (ISCED) level ≥ 4 ; ²Swollen Joint Count >0 ; ³Maastricht Ankylosing Spondylitis Enthesitis Score >0 . *p<0.001. ASDASCRP: Ankylosing Spondylitis Disease Activity Score; ASQoL: Ankylosing Spondylitis Quality of Life questionnaire; CRP: C-reactive protein; CSI: Central Sensitization Inventory; RDCI: Rheumatic Disease Comorbidity Index.

Patients with low ASDAS_{CRP} (<2.1) and also low CSI score (<40) showed good QoL (median ASQoL 1.1). Patients with low ASDAS_{CRP} combined with high CSI score (≥ 40) and patients with high ASDAS_{CRP} (≥ 2.1) combined with low CSI score reported worse QoL (median ASQoL 5.6 and 4.1, respectively). Patients with high ASDAS_{CRP} and also high CSI score reported the worst QoL (median ASQoL 12.0). (Figure 1).

Figure 1. ASQoL score in patients with axSpA with CSI score ≥ 40 and <40 , divided for ASDAS_{CRP} (cutoff 2.1)

Additionally, in univariable analysis, the CSI score explained a large proportion of the variation of the ASQoL ($R^2=0.46$). This association remained significant after correction for ASDAS_{CRP}, gender, symptom duration, enthesal involvement, smoking status, BMI category, educational level and comorbidities in multivariable analysis (CSI p<0.001).

Conclusion: In daily clinical practice, CS seems strongly related to patient-reported QoL in patients with long-term axSpA.

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Acknowledgements: The authors would like to thank all patients who participated in the GLAS cohort. Furthermore, the authors wish to acknowledge Mrs. B. Burmania, Mrs. B. Hollander, Mrs. S. Katerbarg, Mrs. S. Lange, Mrs. E. Markenstein, Mrs. R. Rumph and Mrs. M. de Vries-Veldman for their contribution to clinical data collection.

Disclosure of Interests: Stan Kieskamp: None declared, Davy Paap: None declared, Marlies Carbo: None declared, Freke Wink Consultant of: Abbvie, Reinhard Bos: None declared, Hendrika Bootsma Grant/research support from: Roche, Suzanne Arends Grant/research support from: Pfizer, Anneke Spoorenberg Consultant of: Abbvie, Pfizer, MSD, UCB, Lilly, Novartis, Grant/research support from: Abbvie, Pfizer, UCB, Novartis.

DOI: 10.1136/annrheumdis-2021-eular.4035

POS1015

ANTI-TNF DRUGS AND CARDIOVASCULAR EVENTS IN PATIENTS WITH SPONDYLOARTHRITIS

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Background: Cardiovascular (CVS) diseases are the leading cause of death worldwide and patients with rheumatic diseases have an increased CVS risk including stroke and myocardial infarction (MI) (1-3). CVS risk factors and CVS events are common in SpA (4). Delineating the CVS risk and the association with medications in patients with SpA would be useful.

Objectives: The objective of this study was to delineate the CVS risk and the association with medications in patients with SpA.

Methods: Patients with SpA and patients with non-specific back pain (NSBP) were identified in rheumatology and orthopedics clinics respectively. Clinical information and CVS events were retrieved. Incidence rates were calculated. Association analysis was performed to determine the CVS risk of SpA and other modifiable risk factors.

Results: A total of 5046 patients (SpA 2616 and NSBP 2430) were included from eight centers. Over 56 484 person-years of follow-up, 160 strokes, 84 MI and 262 major adverse cardiovascular events (MACE) were identified. Hypercholesterolemia was more prevalent in SpA (SpA 34.2%, NSBP 28.7%, P<0.01). Crude incidence rates of stroke and MI were higher in SpA patients. SpA was associated with a higher risk of MACE (HR 1.66, 95%CI 1.22-2.27, P<0.01) and cerebrovascular events (HR 1.42, 95%CI 1.01-2.00, p=0.04). The use of anti-tumor necrosis factor (TNF) drugs was associated with a reduced risk of MACE (HR 0.37, 95%CI 0.17-0.80, P=0.01) and cerebrovascular events (HR 0.21, 95%CI 0.06-0.78, P=0.02).

Conclusion: SpA is an independent CVS risk factor. Anti-TNF drugs were associated with a reduced CVS risk in these patients.

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Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.4133

POS1016

ANKYLOSING SPONDYLITIS IN WEST AFRICAN PATIENTS: A SERIES OF 37 CASES REPORTED IN TOGO

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Background: Spondyloarthritis (SpA) is generally uncommon in sub-Saharan Africa, in part because of the rarity of HLA-B27 in this region.

Objectives: The aim of our study was to determine the epidemiological, semiological, paraclinical and therapeutic aspects of ankylosing spondylitis in rheumatology in Togo.

Methods: This was a retrospective multicenter descriptive study on the files of patients suffering from ankylosing spondylitis seen in an outpatient setting or hospitalized in one of the four Rheumatology departments of Togo in the period from January 1, 2000 to December 31, 2019. The diagnosis was essentially radio-clinical based on the modified New York criteria.

Results: In 20 years, and out of a population of 35,304 rheumatic patients, we have collected 37 cases of ankylosing spondylitis, meaning a hospital frequency of 0.10% and an annual frequency of 1.85 cases. There was clearly a male predominance with an M / F ratio of 4.28. The onset of the disease was on average of 29.62 ± 10.27 years and the diagnosis delay on average of 9.45 ± 9.20 years. The clinic was dominated by spinal pain in the form of chronic inflammatory cervical-dorsal-lumbar pain (41.2%) or lumbar pain (29.4%). Common joint injuries were those of the knees (57.69%), ankles (26.9%) and shoulders (23.1%). The most frequent extra-articular manifestations were ocular with conjunctivitis (62.5%) and uveitis (37.5%). Due to the delayed diagnosis, significant spinal deformities including hypercyphosis, straightness and ankylosis were found; the radiography of the spine objectified syndesmophytes (50.0%) with ankyloses and the bamboo column (23.5%) and that of the pelvis objectified sacroiliitis at stage 3 (54.6%) and at stage 4 (27.3%). The HLA B27 antigen was positive in 10.8% of cases. NSAIDs and sulfasalazine were the most commonly used drugs in management, respectively in 94.3% of symptomatic treatment and 92.6% of background therapy.

Conclusion: Ankylosing spondylitis is relatively rare in Togo, affecting more men and young adults. There are no clinical or paraclinical particularity. The delay in diagnosis reflects the importance of the radiological signs. Treatment is mainly done by NSAIDs and DMRADs in particular sulfasalazine, due to their accessibility.

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Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.4199

POS1017

CARDIOVASCULAR RISK IN DIFFERENT CLINICAL VARIANTS OF SPONDYLOARTHRITIS

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Background: Numerous studies have shown that the life expectancy of patients with spondyloarthritis (SPA) is, on average, 5-7 years less compared to the population, and the overall mortality rate is 1.6-1.9 times higher than the population, while mortality from cardiovascular disease increases by 20-40%.

Objectives: of the current study were to assess the cardiovascular risk in pts with with ankylosing spondylitis, psoriatic arthritis and psoriatic spondyloarthritis and to compare different cardiovascular risk scales in these pts.

Methods: The study included 54 patients with SpA aged 45 to 65 years. The patients were divided into 3 groups: patients with ankylosing spondylitis (AS) who meet the modified New York criteria for AS (1984) (n = 14), patients with psoriatic arthritis (PsA) who meet the CASPAR criteria (Classification criteria of Psoriatic Arthritis, 2006) (n = 18) and patients with psoriatic spondyloarthritis (PsSpA) meeting the modified New York criteria for AS and CASPAR criteria for PsA (n = 22).

The average age in the AS group was 55.5 ± 6.43 years, in the PsA group - 57.4 ± 5.76 years, in the PsSpA group - 55.0 ± 6.45 years. Men made up 64.3% in the AC group, 50% in the PsA group, and 49% in the PsSpA group.

Three indices of cardiovascular risk evaluation (Systematic COronary Risk Evaluation (SCORE) with increasing coefficient 1.5 for inflammatory diseases, Reynolds Risk Score (RRS), and the third modification of QRESEARCH Cardiovascular Risk Algorithm (QRISK3) were calculated.

After the numerical assessment of the indicators, each patient was graded in the degree of CVR with the allocation of low, medium, high and very high degree. To stratify the degrees, an estimate of the total risk on the SCORE scale was used: with a value of less than 1%, the risk was considered low, from> 1% to 5% - medium or moderately increased, from> 5% to 10% - high, and> 10% - very high.

Results: The values of the indices were in the AS group SCORE - 3.05±2.41%, RRS - 5.05±2.67%, QRISK3 - 6.68±3.11%, in pts with PsA SCORE - 4.11±2.22%, RRS - 5.72 ± 2.46%, QRISK3 - 7.25 ± 2.51% and in pts with PsSpA SCORE - 4.78 ± 2.65%, RRS - 6.35 ± 2.34 %, QRISK3 - 8.02 ± 3.25%.

Table 1. The number of pts corresponding to different degrees of risk depending on the used CVD risk assessment scale, n = 54

Degrees of risk	SCORE	RRS	QRISK3
Low	9	2	0
Medium	32	26	16
High	12	23	28
Very high	1	3	10

When assessing CVR using various risk assessment scales (RRS, QRISK3, SCORE), the highest values were obtained in the PsSpA group.

When comparing the results obtained, it was found that the majority of the surveyed belonging to a low degree of CVR according to SCORE (9 people), when evaluated using other scales, fell into the group of medium or high risk. The assessment of the risks of 10-year significant cardiovascular events in patients with SPA using the SCORE index does not coincide with the QRISK3 index data in 70.4% of cases, with the RRS data - in 42.6% of cases, and the SCORE index shows lower values of the expected risk. The highest values were obtained when assessing CVR using the scale QRISK3.

Conclusion: The highest CVR values were obtained in the PsSpA group using various risk assessment scales (RRS, QRISK3, SCORE). There was a discrepancy in the severity of CVR calculated using different rating scales in SpA patients. The largest values were obtained when using the scale QRISK3, and the smallest when calculating the CVR using the scale SCORE.

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Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.4209

POS1018

IMPORTANCE OF LATERAL SPINE VIEW IN DXA BONE DENSITOMETRY IN PATIENTS WITH SPONDYLOARTHRITIS

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