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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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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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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POS1018

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

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Background: Osteoporosis is an increasingly important health problem among patients with spondyloarthritis (SPA). The Measure of Bone Mineral Density BMD is routinely carried out in an anteroposterior (AP) view of the spine. However, the syndesmophytes, ligaments calcifications, and the posterior part of vertebrae affect AP scanning. A lateral spine view is a more sensitive tool in assessing bone loss in trabecular bone.

Objectives: We aimed to evaluate the association between lateral lumbar DXA and syndesmophyte grading in patients with SPA.

Methods: We conducted a retrospective study including 75 patients with SPA. Bone density of the hip and lumbar spine was measured with a GE Lunar Prodigy Advance Bone Densitometer equipment. All patients had lumbar lateral, AP, and proximal femur DXA scans. The T-score, which measures the difference between a patient's BMD and young-normal subjects, was computed and age-matched.

Results: The mean age of the patients was 36±11 years. Male predominance was noted with a sex ratio of 4.76. The mean BMI was 25±5 kg/m². Eight percent were obese. Fifty-two percent had Vitamin D deficiency.

Forty-eight percent of the patients had axial SPA, while 52% had axial and peripheral symptoms.

The mean age of onset was 27±7 years. Fifty-two percent of the patients had high inflammatory biomarkers. The BASDAI, ASDAS-VS, and ASDAS-CRP mean levels were respectively: 3.5±2.4, 3.1±0.9, and 3±0.8. The mean BASRI and mass were respectively 8±4.8 and 16.4±19.4. Analyses of T-score values obtained over the femoral neck revealed osteoporosis in 18.7% of the cases and osteopenia in 32% of the cases. On the other hand, analyses of AP, spine views revealed osteoporosis in 25.3% and osteopenia in 45.3% of patients (p=0.028, r=0.254). We detected the highest percentage of osteoporosis in lateral lumbar view and T-scores matched more closely with femoral neck values; osteoporosis in 29.3%, and osteopenia in 22.7% of the patients (p<10-3, r=0.562). BMD measured in AP, and lateral views were in good agreement (p<10-3, p=0.592). Age was inversely but not significantly associated with BMD in lateral (p=0.442, r=-0.09), AP (p=0.319, r=-0.117) and femoral neck projections (p=0.179, r=-0.157). Femoral neck BMD was associated with the activity of SPA (ASDAS vs (p=0.027, r=-0.295), and the mobility limitation BASMI (p=0.032, r=-0.247). Coxitis, BASRI, or mSASS were independent of BMD.

Conclusion: We conclude that spine lateral view in DXA accurately measures BMD exceeding the AP spine views and femoral neck values. Therefore, structural changes do not affect this measurement

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POS1019 INCONSISTENCY OF THE DEGREE OF CARDIOVASCULAR RISK WHEN ASSESSED USING DIFFERENT INDICES IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Evaluation of indicators of cardiovascular risk is one of the main tasks facing a rheumatologist in the tactics of choosing a therapy for patients (pts) with axial spondyloarthritis (axSpA). It is known that pts suffering from axSpA are characterized by a significant increase in cardiovascular risk (CVR). However, there are still no recommendations regulating risk assessment scales in pts with axSpA.

Objectives: were to assess the CVR in pts with axSpA and to compare different cardiovascular risk scales in these pts.

Methods: The study included 55 pts at the age of 45-65 years with diagnosis of axSpA fulfilling ASAS criteria (2009) from St. Petersburg' axSpA register. 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. Risk gradation: low risk (<1%), medium (1.0-4.9%), high (5.0-9.9%), very high (> 10%).

Results: Mean age of the pts was 45.8±10.3 years; males - 37 (67.3%) pts, HLA-B27 positive - 34 (61.8%); mean disease duration 12.5±8.7 years. Mean value of SCORE was 2.83±1.89%, of RRS - 5.04±3.98%, of QRISK3 - 7.91±4.91%. The gradation of the degree of risk depending on the applied assessment index is presented in Table 1.

Index	Results		
	SCORE	RRS	QRISK3
Risk degree			
Low	21 (38,2%)	8 (14,5%)	0 (0,0%)
Medium	26 (47,3%)	23 (41,8%)	17 (30,9%)
High	8 (14,5%)	17 (30,9%)	22 (40,0%)
Very high	0 (0,0%)	7 (12,7%)	16 (29,1%)

Particular attention is drawn to the 100% discrepancy of low risk values when comparing SCORE and QRISK3. A similar trend persisted when comparing medium, high and very high risk. Thus, the assessment of the risks of 10-year significant cardiovascular events in pts with axSpA using the SCORE index does not coincide with the QRISK3 index data in 87.27% of cases, and with the RRS data - in 58.18% of cases. In 84.3% of cases, the mismatch between the SCORE and RRS indexes was due to the presence of an increased CRP level.

Conclusion: When assessing cardiovascular risk in pts with axial spondyloarthritis, a discrepancy was found between the degrees of risk when assessed using different scales. SCORE scores were significantly different from Reynolds' and QRISK3 scores. These features can be interrelated with a small number of factors assessed when calculating the SCORE, even though there is a correction factor for rheumatic diseases. For pts with axial spondyloarthritis, it is necessary to use additional indicators that influence cardiovascular risk, such as CRP.

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Psoriatic arthritis – treatment

POS1020 EFFICACY OF TOFACITINIB ON DACTYLITIS IN INDIVIDUAL DIGITS IN PATIENTS WITH ACTIVE PSORIATIC ARTHRITIS

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Background: Dactylitis, a hallmark of psoriatic arthritis (PsA), is a uniformly diffuse and sometimes painful swelling of the fingers and/or toes.¹ Up to 50% of patients (pts) with PsA may experience dactylitis;^{1,2} as such, dactylitis is an accepted domain of PsA that should be considered in treatment decisions.³ In PsA, dactylitis typically involves feet more than hands; dactylitic joints more frequently have erosive damage, compared with non-dactylitic joints.² There remains a need for effective therapies to treat dactylitis in pts with PsA. Improvements in dactylitis have been associated with tofacitinib, an oral Janus kinase inhibitor for the treatment of PsA.^{4,5}

Objectives: To assess the effect of tofacitinib on dactylitis by location (hands/feet) and individual digit involvement in pts with PsA.

Methods: These post hoc analyses used data pooled from two Phase 3 studies (12-month OPAL Broaden [NCT01877668];⁵ 6-month OPAL Beyond [NCT01882439]⁴) in pts with active PsA treated with tofacitinib 5 mg twice daily (BID; approved dose; to Month [M] 6), tofacitinib 10 mg BID (to M6) or placebo (PBO; to M3); pts were treated continuously with a single conventional synthetic disease-modifying antirheumatic drug. Pts were categorised by the presence of dactylitis at baseline (BL) in the hands and/or feet. Endpoints included change from BL in Dactylitis Severity Score (DSS),⁶ the number of dactylitic digits and the proportion of pts with dactylitis in individual digits at M1, M3 and M6. Descriptive statistics were generated by visit and treatment arm.

Results: Data were pooled from 373 pts with DSS >0 at BL. BL characteristics, including gender, age, race, body mass index, PsA duration, BL DSS and dactylitic digits count were similar across dactylitis groups and treatment groups, except for pts with dactylitis in both the hands and feet, who had higher DSS compared to those with dactylitis in the hands or feet only, likely due to having more dactylitic digits (data not shown). Regardless of location, pts treated with tofacitinib had cumulative improvements from BL to M6 in DSS (Figure 1a) and in the number of dactylitic digits (Figure 1b); improvements in DSS were greater at M1 and M3, compared with PBO. Pts treated with tofacitinib 10 mg BID typically had numerically greater improvements in DSS, compared with pts treated with tofacitinib 5 mg BID (Figure 1a). Most pts treated with tofacitinib experienced improvement of dactylitis across all fingers and toes (Figure 1c-f); mean dactylitis presence was ≤15% at M6 in pts treated with tofacitinib for all digits. Generally, at M1 and M3, fewer pts treated with tofacitinib had dactylitis in any digit, compared with PBO (Figure 1c-f).

Conclusion: Among pts with pre-existing dactylitis, treatment with tofacitinib resulted in improvements in dactylitis in hands, feet, or both, and in all digits as early as M1, and up to M6.