Methods: The resurvey (Stage I) was carried out using the methods of the previous survey (Bhigwan COPCORD model 1996). Trained voluntary health workers (HW) completed a house-to-house cross-sectional survey (Phase 1) of the study population. Biostatisticians (AS) and past MSK pain respondents. Pain due to recent trauma (< 3 months) was excluded. Concur- rently, the respondents were also evaluated (Phase 2) for pain descriptors and other relevant issues. Rheumatologists examined (Phase 3) the respondents to make a clinical diagnosis, order relevant investigations, and begin treatment. A follow-up was scheduled. The target population was estimated at 8117 (Government records). The database was created using an indigenous software program. Standard population analysis was carried out. Crude point prevalence rates (95% confidence intervals) are presented. Further analysis is being done. Results: 6970 population (85.9% response, 50% males) was surveyed. The age–gender distribution pattern was comparable with the India rural census 2011; 63% in 18-44 years age groups (Bhigwan). Paradoxically, only 76% current pop- ulation in sharp contrast to about 55% in 1996 admitted working (physically) in fields; now dependent upon temporary migrant labor (not in the survey). 32% population possessed mobile phones. Five hundred eighty-six pain patients (women 69%) were identified; 46% belonged to the 45-64 years age group. The MSK pain prevalence was 8.2% (7.5%, 8.8%); male 2.5 (2.2%, 2.9%), female 5.6% (5.1, 6.2). 14.2% population used tobacco in some form, mostly oral; 36.3% of MSK pain respondents (58% women). Hypertension in 79%, diabetes in 4.7%, thyroid disorders in 1.6%, and rectal hemorrhoids in 1% was self-reported in the population; correspondingly 25%, 12.2%, 2.5%, and 3% were reported by the MSK pain cohort. Past history of Chikungunya in 5.7% and COVID-19 in 74% of the total population was reported. On univariate analysis, MSK pain was significantly associated (p = 0.0001, Chi-square) with Chikungunya, COVID-19, tobacco use, fieldwork, and low education status. Prevalence rates for disease groups were 1.38% (11.2, 1.68) for inflammatory arthritis, 3.66% (3.23, 4.13) for degenerative arthritis and 2.87% (2.49, 3.29) for non-specific rheumatism/arthritis. Self-re- ported data, subject recall, and limited investigations were important concerns. Conclusion: The current COPCORD survey shows that despite a substantial reduction from 1996, MSK pain continues to be a predominant and important self-reported illness in the Bhigwan rural community. Undoubtedly, the lives and livelihoods of the Bhigwan people and their MSK landscape have been trans- formed substantially. Interestingly, the burden of other non-communicable dis- eases seems increased. Further research studies will be required to unravel the role of Chikungunya and COVID-19, and other risk factors in MSK disorders.REFERENCES:
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Disclosure of Interests: None Declared.
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AB1664 INFLUENZA, PNEUMOCOCCAL, AND TETANUS VACCINE COVERAGE AMONG PATIENTS WITH INFLAMMATORY RHEUMATIC DISEASES ON BIOLOGICAL OR TARGETED SYNTHETIC DMARDs AND THE ROLE OF THE RHEUMATOLOGIST

Keywords: Vaccination/immunization T. Georgiev1, R. Moraliyska2, S. Bogdanova-Petrova1, S. Dimitrov3, S. Hristova3, D. Simeonova1, G. Gerganov1, T. Shivacheva1.
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Background: Vaccines are one of the most efficient tools to prevent infectious diseases at a population level. Their importance is even greater in immunocom- promised patients providing efficient and safe protection against common viral and bacterial infections. According to the current EULAR recommendations based on solid evidence over the recent years, non-live vaccines such as influ- enza, pneumococcal, and tetanus toxoid, and others are safe and can be adminis- tered to patients with inflammatory rheumatic diseases during the glucocorticoid and/or disease-modifying antirheumatic drug (DMARD) therapy. Furthermore, influenza and pneumococcal vaccines “should be strongly considered” and the tetanus toxoid vaccination should be received in accordance with the recommenda- tions of the general population.
Objectives: We aim to investigate the coverage for influenza, pneumococcal, and tetanus toxoid vaccination in a cohort of patients with inflammatory rheu- matic diseases on biological or targeted synthetic DMARDs.
Methods: Two hundred and one patients, aged 18 or older, were included in this single-center cross-sectional study after signing an informed consent form. They suffered from rheumatoid arthritis (RA), psoriatic arthritis (PsA), or anky- loid spondylitis (AS) and were treated with targeted synthetic DMARDs or targeted synthetic DMARDs and biologicals in addition. Data from patients with psychiatric or neurological diseases preventing understanding or responding to the questions were excluded from the study. Patients’ anthro- pometric, clinical, and demographic characteristics were collected via detailed anamnesis and clinical examination. Disease activity was evaluated using DAS28- CRP for patients with RA and peripheral PsA and ASDAS for those with axial disease (AS and axial PsA). All patients were asked to fill in a survey deter- mining their immunization status for influenza, pneumococcal, and tetanus toxoid vaccines and whether they had a preceding discussion with their rheumatolo- gist about recommended vaccines during their routine medical visits.
Results: Of the 201 included patients, 40.3% (n=81) were females. Patient dis- tribution according to their disease was as follows: 30.3% (n=61) RA patients, 51.7% (n=104) AS patients, and 17.9% PsA patients (n=36). Mean age, gender, duration, and body mass index values were 54.62 (14.4) years, 11.04 (8.6) years and 28.2 (5.3), respectively. 27.4% of patients were on concomitant glucocor- ticoic treatment. Only 13.9% (n=28) and 1.5% (n=3) were vaccinated against seasonal influenza and pneumococcal infections, respectively. Patients who had a preceding discussion about seasonal influenza and pneumococcal immuni- zation with their rheumatologist had approximately 13 and 32 times higher probability to get vaccinated than people who did not (OR=12.9, p < 0.001 and OR 32.5, p = 0.01, respectively). Regular reimmunizations against diphtheria and tetanus according to the Immunization Calendar of the Republic of Bulgaria were carried out by only 44.8% (n=90) of the studied population.
Conclusion: Coverage of recommended vaccines in our group of Bulgarian patients on biologic or targeted synthetic DMARDs is very low. Discussion about the potential benefits and safety profile of the recommended vaccines may increase patients’ willingness to vaccinate and prevent common infectious dis- eases in immunocompromised rheumatic patients.
REFERENCES:
Acknowledgements: NIL.
Disclosure of Interests: None Declared.
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AB1665 NON-IMPAIRED KIDNEY FUNCTION INCREASES HYPERURICAEMIA-ASSOCIATED MORTALITY RISK EFFECT

Keywords: Epidemiology, Kidneys, Gout T. Timsø1, J. Kauppi2, A. Kerola3-4, T. Lehto5, H. Kauhitainen6, M. Kauppi1-4, J. Pålät-Häme Central Hospital, Department of Rheumatology, Lahti, Finland; 1Pålät-Häme Central Hospital, Unit of Physiatry and rehabilitation medicine, Lahti, Finland; 2Helsinki University Central Hospital, Inflammation Center, Helsinki, Finland; 3University of Helsinki, Faculty of Medicine, Helsinki, Finland; 4Finnlab Laboratory Oy, Department of Clinical Chemistry, Lahti, Finland; 5University of Helsinki, Folkhälsoan Research Center, Helsinki, Finland.
Background: Both hyperuricaemia and reduced kidney function are known mor- tality risk factors.[1-3] Also, hyperfiltration is associated with elevated mortality risk.[3] It has not yet been studied if renal function has a modifying effect on hyperuricaemia-associated mortality risk.
Objectives: To detect if renal function has a modifying effect on hyperuricae- mia-associated mortality risk.
Methods: Data from GOAL (Good Ageing in Lahti region) study was used. It is a large, prospective, population-based study of elderly people (52–76 years) in the Lahti region. Data of serum uric acid (SUA) levels, creatinine, cystatin C as well as several other laboratory variables, comorbidities, lifestyle habits and socioeco- nomic factors was collected. To estimate glomerular filtration rate, we used CKD- EPI creatinine-cystatin C equation (mL/min/1.73 m²). Patients with SUA values of >410 μmol/L (75th percentile) are represented as clearly hyperuricaemic. Persons with eGFR of <67 mL/min (25th percentile) are represented as having reduced kidney function. The results were adjusted for age, gender, education, smoking status, alcohol consumption, body mass index, blood pressure, and diabetes. Results: Mortality was higher in individuals with reduced kidney function compared to those with eGFR of >67 mL/min both in the group of clearly hyperuricae- mic persons and in the group of persons with SUA ≥410 μmol/L. The hazard ratio (HR) for all-cause mortality was 1.53 (95% CI: 1.26 to 1.84) in clearly hyperuricae- mic persons with reduced kidney function, 1.26 (95% CI: 1.02 to 1.55) in clearly hyperuricaemic persons with ≥410 μmol/L, and 1.26 (95% CI: 1.03 to 1.55) in persons with SUA ≥410 μmol/L and reduced kidney function, while the group of
Table 1. Adjusted hazard ratio (HR) for all-cause mortality in persons with preserved or reduced estimated glomerular filtration rate (eGFR) and clearly elevated serum uric acid (SUA) level or slightly elevated/normal SUA level

<table>
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<tr>
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<th>SUA ≤410 μmol/L</th>
<th>SUA &gt;410 μmol/L</th>
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<tr>
<td>eGFR ≤67</td>
<td>1.00 (Reference)</td>
<td>1.26 (1.02 to 1.55)</td>
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<tr>
<td>eGFR &gt;67</td>
<td>1.26 (1.03 to 1.55)</td>
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Figure 1. The impact of estimated glomerular filtration rate on hyperuricaemia-associated mortality risk effect.