

EspAax incluidos en REGISPONER en el Hospital Universitario Reina Sofía de Córdoba.

**Métodos:** Estudio analítico observacional de cohortes retrospectivo, en el que se analizaron 78 pacientes pertenecientes al registro REGISPONER, los cuales fueron evaluados por primera vez en el año 2004-2005. Se han evaluado las últimas radiografías de columna cervical, columna lumbar, pelvis y de caderas registradas en la historia clínica de los pacientes. Para el cálculo del índice BASRI se evalúan las radiografías registradas en la visita de seguimiento por dos observadores de forma independiente y se estudia la concordancia interobservador utilizando el estadístico Kappa de Cohen. La progresión radiográfica se evaluó a través del test de McNemar.

**Resultados:** De los 78 pacientes incluidos en el estudio disponemos de estudio radiográfico de 61 pacientes con una media de 11 (1,7) años desde la exploración radiológica basal, con un estudio radiográfico completo (incluyendo raquis cervical, lumbar, pelvis y caderas) en 38 de ellos. Las características basales, incluidos los valores de BASRI basal, de los 38 pacientes que se incluyeron en el análisis de progresión están recogidos en la tabla 1, así como el tratamiento actual de la cohorte de pacientes. La fuerza de la concordancia interobservador en la lectura radiográfica fue casi perfecta a nivel de columna cervical ( $k = 0,88$ ;  $p < 0,001$ ), columna lumbar ( $k = 0,87$ ;  $p < 0,001$ ), articulaciones sacroilíacas ( $k = 0,84$ ;  $p < 0,001$ ) y considerable en caderas ( $k = 0,77$ ;  $p < 0,001$ ) con una puntuación de BASRIs 7,5 (2,9) y BASRIt 8,8 (4,1). Se produjo un incremento de BASRIt en 1,23 ( $p = 0,014$ ) durante el tiempo de seguimiento. Analizando individualmente los diferentes componentes del BASRI observamos que un 42,1% empeoraron en cuanto a la puntuación correspondiente a columna cervical ( $p < 0,001$ ), un 28,9% en columna lumbar ( $p = 0,057$ ), un 15,8% en cadera ( $p = 0,754$ ) y no se encontró empeoramiento en sacroilíacas ( $p = 0,500$ ).

Tabla 1. Características basales y tratamiento actual de la cohorte N = 38 para el estudio radiográfico

Tipo SpA, N (%)	EA 38 (100%)	BASRIs basal Media (DE)	6,44 (2,91)
Tiempo de evolución desde diagnóstico hasta inclusión en el registro, media (DE) años	11 (7,1)	BASRIt basal Media (DE)	7,60 (3,96)
Sexo, N (%)		Grado sacroilíacas Me (RI)	4 (3-4)
Hombre	34 (89,5)		
Mujer	4 (10,5)		
Edad, media (DE) años	58,2 (7,9)	Grado C. Cervical Me (RI)	1 (0-2)
		Grado cadera Me (RI)	1 (0-2)
Tratamiento actual, N (%)			
AINE	Continuo: 22 (57,9%) A demanda: 13 (34,2%) Respuesta: 35 (92,1%) Tipo: 18 COXIBs (51,4%) 7 Diclofenaco (18,4%) 5 Indometacina (13,2%) 5 Otros (13,2%)		
FAMEs	Salazopirina 1 (2,7%) Metotrexate 1 (2,7%)		
Biológico	10 (26,3%) 4 Golimumab (10,5%) 3 Etanercept (7,9%) 1 Adalimumab (2,6%) 1 Infliximab (2,6%) 1 Secukinumab (2,6%)		

Me: Mediana. RI: Rango intercuartílico.

Tabla 2. Evaluación radiográfica basal y tras 13 años de seguimiento

	T0 (N = 38)	T1 (N = 38)	P
Columna cervical Me (RI)	1 (0-2)	2(0-3)	0,003
Columna lumbar Me (RI)	1 (1-3)	2 (1-3)	0,053
Sacroilíacas Me (RI)	4 (3-4)	4 (3-4)	0,285
Caderas Me (RI)	1 (0-2)	1 (0-2)	0,545
BASRIs Media (DE)	6,44 (2,91)	7,55 (2,98)	0,16
BASRIt Media (DE)	7,60 (3,96)	8,84 (4,12)	0,006

Me: mediana, RI: Rango intercuartílico. Significación estadística basada en t de Wilcoxon.

**Conclusiones:** Este estudio aporta información sobre la progresión estructural de pacientes seguidos en una consulta monográfica de espondiloartritis tras 13 años de seguimiento. Observamos una evolución radiográfica discreta pero significativa en relación a la puntuación total del BASRI. Sin embargo, analizando las puntuaciones individuales parece que la columna cervical fue el segmento donde se produjo una mayor progresión radiográfica. No encontramos empeoramiento de BASRI en sacroilíacas debido a que la mayoría de los pacientes ya presentaban un grado avanzado de sacroileitis en la primera visita del registro.

### P375. HOPES AND FEARS OF PATIENTS WITH AXIAL SPONDYLOARTHRITIS IN SPAIN. THE VALUE OF PATIENT OPINION: RESULTS FROM THE SPANISH ATLAS

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**Introduction and objectives:** Not much attention has been paid to listening to the opinions of patients in most scientific studies on spondyloarthritis, despite their opinions playing an increasingly important role in decision-making alongside clinical and public health criteria. To assess the opinions of patients with Axial Spondyloarthritis (ax-SpA) using qualitative information.

**Methods:** A sample of 680 patients diagnosed with ax-SpA was interviewed during 2016 as part of the Spanish Atlas, which aims to promote early referral and improve healthcare and the use of effective treatments in patients with ax-SpA. The Atlas is a CEADE initiative (Spanish Coordinator of Patients with ax-SpA in Spain) developed by the University of Seville and Max Weber Institute in collaboration with GRESSER (Spanish Rheumatology Society spondyloarthritis study group). Responses to qualitative items about patients' hopes and fears for their disease and their personal aims regarding their treatment were analysed.

**Results:** 53% were females, mean age 46 years and 77,1% were HLA-B27+. The five main hopes of patients are: stopping the disease, dream of a cure, elimination of pain, improve their quality of life and live without limitations. Additionally, patients has expectations on the medical research outcomes. Thus, 81% of patients hope that the research will make possible to find the cause and a cure for ax-SpA, developing more efficient biologic therapies (11%), and finding new techniques or medication (8%). The following stand out among drug treatment-related concerns: having more effective treatments (32%), sustaining the results of biologic therapies (29%), being able to start on biologics (8%), the public health system funding non-drug treatments for AS (8%), eliminating secondary effects (15%), reducing prices (4%), and correct use (4%). With respect to their fears, patients stated that their main concern was mobility loss (31%), followed by loss of independence (23%), disability (22%), stiffness (12%), structural damage (3%), organ damage (3%), other illnesses and diseases related (3%), physical decline (3%), and sight loss

(1%). Patients who expressed fear regarding their disease listed their greatest concern was that they would not overcome or tolerate pain (56%), followed by the fear that the disease would develop (32%), along with apprehension about flare-ups (7%), and tiredness (5%). With respect to patients' personal objectives in terms of their treatments, they highlighted the wish that their treatment would, first, help them to reduce and eliminate pain, increasing their in mobility, improved quality of life, the avoidance of structural damage and the disease eventually being cured.

**Conclusions:** Analysis of patient opinion using qualitative information has enabled the identification of important concerns for patients such as discovering the cause of the disease, reducing pain and structural damage, loss of self-sufficiency and disability. The Atlas was funded by Novartis and done in collaboration with CEADE.

### P376. MENTAL HEALTH IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS: INCREASING OUR UNDERSTANDING OF THE DISEASE. RESULTS FROM THE SPANISH ATLAS

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**Introduction and objectives:** This study's aim was to assess the association between sociodemographic characteristics, disease progression, and mental health comorbidity with risk of mental disorders (RMD).

**Methods:** In 2016 a sample of 680 axSpA patients was interviewed as part of the Spanish Atlas. To quantify the RMD, Goldberg's General Health Questionnaire (GHQ-12) scale was employed. Possible RMD predictors analysed were: sociodemographic characteristics (age, gender, being part of a couple, patient association membership, job status); disease characteristics (BASDAI, spinal stiffness ranging from 0-3, functional limitation in 18 daily activities ranging from 0-3); and mental health comorbidities (depression and anxiety). All clinical variables showed a Cronbach's alpha coefficient guaranteeing the reliability of the scales used. First, a descriptive analysis was employed to describe the sample and study variables. Second, we performed univariate correlation and homogeneity analyses between each predictor (independent variable) and RMD (GHQ-12). Third, selection of variables that showed statistical significance in the univariate analyses in order to conduct a multiple hierarchical and stepwise regression analysis.

**Results:** All variables except educational level and thoracic stiffness showed significant univariate correlation with RMD. BASDAI, functional limitation and age showed higher coefficient ( $R = 0.543$ ,  $R = 0.378$ ,  $R = -0.174$ , respectively). Multiple Hierarchical regression analysis showed as sociodemographic variables explained in great detail the RMD ( $R^2 = 83.2\%$ ). By contrast, having established sociodemographic as a control variable, the inclusion of depression and anxiety to the model increase the  $R^2$  value to just 0.6% ( $p = 0.001$ ), while the inclusion of variables related to the disease characteristics add 5.5% ( $p = 0.000$ ) to the GHQ-12 punctuation variability. The only variables presenting a significant coefficient different from 0 were BASDAI (0.52,  $p = 0.000$ ) and functional limitation (0.14,  $p = 0.004$ ). This suggests that once the sociodemographic and mental comorbidity variables are established, a change to BASDAI levels or functional limitation impacts the GHQ-12 score. In the stepwise regression analysis, four variables (BASDAI, functional limitation, association membership, cervical stiffness) showed a significant relation to GHQ-12 and explained the majority of RMD variability. BASDAI displayed the highest explanatory degree ( $R^2 = 0.875$ ).

Sample characteristics (n = 474, unless other specified)

Variables	Values (means $\pm$ SD or percentage)
Age, mean $\pm$ SD	45.43 $\pm$ 10.78
Sex, No. of men	233 (49.16%)
Having a couple, No. of participants (N = 444)	386 (86.94%)
Education level, No. of university studies	185 (39.30%)
Job status, No. of unemployed	68 (14.35%)
Association Membership	227 (47.89%)
BASDAI, mean $\pm$ SD (N = 442)	5.49 $\pm$ 2.17
Cervical stiffness, No. (N = 447)	201 (44.97%)
Thoracic stiffness No. (N = 435)	186 (42.76%)
Lumbar stiffness No. (N = 458)	288 (62.88%)
Functional Limitation, mean $\pm$ SD (N = 473)	27.54 $\pm$ 12.78
Depression, No. (%) (N = 474)	99 (20.89)
Anxiety, No. (%) (N = 474)	134 (28.27)
GHQ-12, mean $\pm$ SD	18.30 $\pm$ 8.01

**Conclusions:** Patients at certain sociodemographic levels are more prone to present a higher BASDAI. Taking these conditions for granted, the degree of disease progression measured by BASDAI is a good indicator of RMD. Therefore, in those with higher disease activity, psychiatric evaluation and intervention should be considered within the medical treatment.

The Atlas was funded by Novartis and done in collaboration with CEADE.

### P377. ASSOCIATION BETWEEN SMOKING WITH SPINAL LEVEL OF STIFFNESS AND FUNCTIONAL LIMITATION IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS: RESULTS FROM THE SPANISH ATLAS

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**Introduction and objectives:** Smoking has been associated with greater disease activity and radiographic progression in patients with Axial Spondyloarthritis (ax-SpA). In addition, radiographic damage has been linked to greater functional limitation. However, clarification is still being sought as to whether or not this association exists. To investigate the association between smoking and both the area of spinal stiffness and functional limitation in patients with ax-SpA.

**Methods:** A sample of 680 patients diagnosed with ax-SpA was interviewed during 2016 as part of the Spanish Atlas, which aims to promote early referral and improve healthcare and the use of effective treatments in patients with ax-SpA. Tobacco consumption was recorded as: Smoker (62.4%), Occasional Smoker (8.9%) and Non-Smoker (28.7%). Spinal stiffness was assessed in the three different vertebral areas: cervical, dorsal and lumbar. To determine the degree of functional limitation we used a composed index which includes the sum of the degree of limitation in the 18 daily activities well established (dressing, grooming, bathing, tying shoelaces, moving around the home, stairs, getting to/out of bed, toilet, shopping, preparing meals, eating, cleaning, walking, using public transportation, going to the doctor, driving, physical exercise, sexual relations) using an ordinal variable (0 = none, 1 = little, 2 = some and 3 = moderate). A descriptive analysis was used to compare the level of stiffness (chi-squared test) and the mean degree of limitation (Kruskal-Wallis test) in the different groups of smokers consumptions. Regression analysis was also used to assess the relation between smoking and degree of limitation (0-54).

**Results:** 53% were females, mean age 46 years and 77.1% were HLA-B27+. The percentage of patients with stiffness in the lumbar region was significantly higher in habitual/occasional smokers than in non-smokers (89.0%, 93.8%, 83.5% respectively;  $p < 0.01$ ) (Table). The mean degree of functional limitation increased with tobacco consumption, although this difference was not statistically significant (47.9  $\pm$  12.1 vs 45.1  $\pm$  11.5 vs 44.8  $\pm$  13.7 respectively;  $p = 0.2$ ). How-