

derburn (Centre for Rheumatology, University College London, UK), N. Wulffraat (Department of Pediatric Immunology, University Medical Centre Utrecht, Utrecht, The Netherlands), B. Bader-Meunier (Department for Immunology, Hematology and Pediatric Rheumatology, Necker Hospital, Paris, France), E. Baidam (Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool, UK), T. Constantin (Semmelweis Hospital, Budapest, Hungary), B. Feldman (Department of Rheumatology, The Hospital for Sick Children, Toronto, Ontario, Canada), P. Lahdenne (Department of Pediatric Rheumatology, Children's Hospital, Helsinki University Central Hospital, Helsinki), B. Magnusson (Astrid Lindgren Children's Hospital, Department for Pediatric Rheumatology, Karolinska University Hospital/Stockholm, Sweden), K. Nistala (Centre for Rheumatology, University College London, UK), C. Pilkington (Centre for Rheumatology, University College London, UK), A. Ravelli (Istituto Giannina Gaslini, Pediatria II, Reumatologia, Paediatric Rheumatology International Trials Organisation (PRINTO) Coordinating Center, Genoa, Italy), R. Russo (Service of Immunology and Rheumatology, Hospital de Pediatría Garrahan, Buenos Aires, Argentina).

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7286

WEDNESDAY, 14 JUNE 2017

Ultrasound basic I & II

SP0037 HOW TO ASSESS US ELEMENTARY LESIONS IN CPPD

G. Filippou. *University of Siena, Siena, Italy*

Ultrasonography has been increasingly used the last years for the identification of calcium pyrophosphate dihydrate crystal deposition (CPPD) in joints and on 2011 has been considered by the EULAR task force on CPPD as a promising tool for the diagnosis of the disease. However, it is common experience between sonographers that in daily clinical practice CPP identification by US is rather challenging as crystal deposits are not always numerous and diffuse. Furthermore, other conditions can mimic CPP deposition leading to a wrong diagnosis. The recently created OMERACT US for CPPD subtask force has created for the first time a set of criteria for identification of CPP deposition and assessed their reliability trying to address some of the issues that impede a wider use of US for CPPD diagnosis. During this section will be exposed the main US features of CPP deposition according to the new criteria as well as the principal pitfalls that could mislead diagnosis. The scanning technique and some tips and tricks that could help sonographers to identify correctly CPP deposition will also be explained.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7251

SP0038 HOW TO ASSESS CARTILAGE IN RA AND PITFALLS + DEMO

P. Mandl. *Rheumatology, Medical University of Vienna, Vienna, Austria*

Cartilage damage is a key process in rheumatoid arthritis which appears to be more clearly associated with irreversible physical disability than bony damage. While conventional radiography only allows the evaluation of joint space narrowing, a proxy measure of cartilage loss, musculoskeletal ultrasound is a reliable tool for evaluating cartilage damage. The presentation will introduce the pitfalls and challenges associated with visualizing cartilage in rheumatic diseases in general and rheumatoid arthritis in particular. It will also review recent studies in the field which have validated sonography for both the quantitative measurement of cartilage thickness and for the semiquantitative scoring of cartilage change. A practical demonstration will also be provided.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7274

SP0039 HOW TO EVALUATE THE SUBTALAR JOINT

A. Iagnocco. *Università degli Studi di Torino, Torino, Italy*

The subtalar joint, also known as the talocalcaneal joint, is a synovial joint of the foot, that occurs between the talus and the calcaneus with the talus that is oriented slightly obliquely on the anterior surface of the calcaneus. The two bones articulate at two different sites (i.e. one anteriorly and one posteriorly). The *anterior talocalcaneal joint* is a convex area of the talus that fits on a concave surface of the calcaneus. The *posterior talocalcaneal joint* is formed by a concave surface of the talus and a convex surface of the calcaneus.

The subtalar joint contributes to the dorsiflexion of the ankle. Three articulating facets (anterior, middle and posterior) are present between the talus and the calcaneus. The sustentaculum tali forms the floor of middle facet, and the anterior facet articulates with the head of the talus, and sits lateral and congruent to the middle facet. The posterior facet is the largest of the three, and separated from the others by the tarsal canal. The most relevant actions done by the joint are inversion and eversion of the foot. The subtalar joint can also be considered a combination of the anatomic subtalar joint discussed above, and the talocalcaneal part of the talocalcaneonavicular joint. When both those joints are accounted together, it allows for pronation and supination to occur.

The subtalar joint is frequently involved in arthritis and, particularly in patients with

previous sprains, secondary osteoarthritis can also occur. Symptoms of subtalar joint arthritis include pain, loss of motion through the joint's range of motion, and difficulty walking on uneven surfaces.

Among the imaging techniques that are appropriate for the assessment of the subtalar joint, ultrasound (US) has been increasingly used over the last years. Indeed it is able to image different abnormalities, including both inflammatory and structural changes, and it is helpful in guiding local procedures that can be easily and safely performed with optimal patient's tolerance.

The US scanning technique is quite complex, and the whole joint area should be scanned in the longitudinal (sagittal or coronal) plane with pathology that should be confirmed in the orthogonal (perpendicular) plane. By using a standardised scanning technique and agreed definitions of pathology, US allows an optimal assessment of inflammatory and structural abnormalities, thus filling the gap between clinical and radiographic evaluations of the subtalar joint.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7292

SP0040 HOW TO SCAN THE HIP, NEW APPROACH AND DEMO

I. Möller on behalf of EULAR Working Group Anatomy for the IMAGE. *Rheumatology; anatomy; sonoanatomy-sonopathology, Instituto Poal de Reumatologia; University of Barcelona, Hospitalet de Llobregat, Spain*

The exploration of the hip includes not only intraarticular findings such as synovitis or lesions of the labrum but also the dynamic exploration of the tendons and muscles surrounding it as well as of the neurovascular bundles of interest. All this is an essential complement in the differential diagnosis of the rheumatic patient. The iliopsoas tendon as well as the hip adductors will be demonstrated during the presentation. The anterior and antero internal part of the groin region constitute a relatively frequent consultation and study of the tendinous snapping and its differential diagnosis with the snapping of intraarticular origin can be made by means of the musculoskeletal ultrasound. It requires systematization and knowledge of the regional anatomy.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7156

WEDNESDAY, 14 JUNE 2017

Rehabilitation and modern drug treatment - needs and challenges

SP0041 CURRENT NEEDS FOR REHABILITATION

M. Björk. *Department of social and welfare studies, Linköping University, Norrköping, Sweden*

New biological medications and earlier multi professional interventions have led to a reduction in the extent of disability for patients with rheumatic diseases. However disability still remains a key problem for many patients and patients may experience participation restrictions even though they are achieving "remission". To be able to engage in the things we want or need to do is crucial to our health and sometimes a challenge to meet for health professionals. Also, there is an on going discussion of whether today's patients have new rehabilitation needs and if they are met by the health care. This session summarizes both qualitative and quantitative evidence of the disability in today's patients with arthritis. It will further discuss the current needs of rehabilitation in today's patient in relation to existing standards and guidelines. Rehabilitation interventions and patient reported strategies in relation to pain, fatigue and affected activity balance will be highlighted since they are common disabilities among today's patients.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7269

SP0042 THE ART OF JUGGLING - A PATIENT'S PERSPECTIVE

F.M. Catrina. *LRR, Bucharest, Romania*

Diagnosed with ankylosing spondylitis since 2006, when just turned 24 years old. I was very demoralized and could not understand why I have rheumatic pains bigger than my grandmother 70 years old. I did not understand why I can not go, just do anything wrong to anyone. Slowly, slowly I began to understand the disease and help doctors started to move again. But my secret to healthy aging, was family. Therefore we understand that positive thinking can help me more than any drug, and how you can have a more positive attitude as if in a nice family environment?

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7139