no association of dose of non-purine-like XO1 with incidence of TCE and SAE. Significant statistical heterogeneity was not observed in any test reported here.

Figure 1. Meta-regression analysis of dose of allopurinol versus logarithm of odds ratio (OR) of serious adverse events.

Conclusions: Our data from a meta-analysis of RCTs suggest that XO1 reduce the incidence of CV events, an effect possibly related (at least partly) to control of hypertension. However, higher doses of allopurinol (>300 mg/day) may possibly be associated with higher risk of serious adverse events and loss of cardiovascular protection.

References:

- [1] Richette et al. *Nat Rev Rheumatol* 2014;10:654–61.
- [2] Singh et al. *Arthritis Res Ther* 2016;18:209.
- [3] Agarwal et al. *J Clin Hypertens (Greenwich)* 2013;15:435–42.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.2674

FRIDAY, 16 JUNE 2017

Low back pain and fibromyalgia

OP0270 LONG-TERM PROGNOSIS IN CHRONIC PLANTAR FASCIITIS BASED ON DISEASE DURATION AND ULTRASONIC CHANGES

L. Hansen¹, U. Fredberg¹, T.P. Krogh¹, T. Ellingsen^{1,2}, L.B. Hansen³.
¹Diagnostic Centre, Regional Hospital Silkeborg, Silkeborg; ²Department of Rheumatology, Odense University Hospital, Odense; ³Radiologic Department, University Hospital Aarhus, Aarhus, Denmark

Background: Plantar fasciitis (PF) affects 7–10% of the population over a lifetime but the long-term prognosis is unknown. This study is the greatest within the long-term prognosis of PF and have the longest follow-up time.

Objectives: The aim was to assess the long-term prognosis of chronic PF based on duration of symptoms and ultrasonic changes (tendon thickness, heel spur, echogenicity and heel fat pad) and assess if any baseline cohort characteristics had an impact on the prognosis (sex, BMI, age, smoker status, physical work/sport and bilateral pain).

Methods: At baseline (2001–11) 269 patients were diagnosed with PF based on symptoms and ultrasound findings.

At follow-up (2016) all the participants were invited to participate in the project. Everyone was interviewed and offered a new ultrasound examination of their plantar fascia at both feet.

Results: 174 (65%) participated in the study, 52% women and 48% men and 137 had an additional US examination. 54% of the participants were asymptomatic at follow-up (asymptomatic group) and the mean duration of symptoms were 725 days (range 41–4018). 46% still had symptoms (symptomatic group). The follow-up period was 9.7 years (range 4.7–27.3). The risk of having chronic PF were 45.6% (95% CI 37.9–53.0) 10 years after debut of symptoms (figure 1). A multiple cox regression analysis found that women (p<0.01) and participants with bilateral heel pain (p<0.01) had a worse prognosis. The hazard rate ratio was 0.49 (95% CI 0.30–0.80) for women (every time 100 men were getting cured pr. year only 49 women were cured pr. year) and 0.33 (95% CI 0.15–0.72) for participants with bilateral heel pain (every time 100 with unilateral pain were cured pr. year only 33 with bilateral pain were cured pr. year). The remaining baseline cohort characteristics (all p's>0.05), tendon thickness (p=0.49) and heel spur (p=0.88) did not have an impact on the prognosis (table 2).

The mean tendon thickness was at baseline 6.9 mm in the asymptomatic group and 6.7 mm in the symptomatic group. The tendon thickness was reduced significantly to 4.3 mm at follow-up in both groups (both p's<0.01). Only 24% in the asymptomatic group had a normal tendon thickness and echogenicity at follow-up (6% in the symptomatic group).

The participants had in average tried 3.8 (range 1–9) different treatment modalities and 93% received an ultrasound guided steroid injection at baseline. 11% of them were permanently cured 1 month after the injection despite symptoms for an average of 334 days' prior the injection. No atrophy of the heel fat pad was found in the sick foot who got the steroid injections compared to the contralateral foot that did not get the injection (p=0.66).

Conclusions: 45.6% had PF 10 years after debut of symptoms. The asymptomatic participants had in average plantar fasciitis for 725 days. The prognosis was significantly worse for women and participants with bilateral pain.

Figure 1:

Kaplan Meier survival function for all the participants. The y-axis shows the part who is symptomatic (1.00=100% is symptomatic). And the x-axis is the time in year since debut of symptoms (year 0 = debut of symptoms).

The tendon thickness decreased over time no matter of symptoms and had no impact on the prognosis, neither did heel spur.

Only 24% of the asymptomatic participants had a normal tendon on ultrasound at long-term follow-up.

Ultrasound guided steroid injection did not give atrophy of the heel fat pad in long-term follow-up.

Acknowledgements: The project was financed by The Danish Rheumatism Association and The Research Funds of Hospital Unit Central Jutland

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3152

OP0271 CORTICOSTEROID INJECTIONS FOR GREATER TROCHANTERIC PAIN SYNDROME: A RANDOMIZED DOUBLE-BLIND PLACEBO-CONTROLLED TRIAL

M.J. Nissen¹, L. Brulhart², A. Faundez³, A. Finckh¹, D. Courvoisier¹, S. Genevieve¹. ¹Rheumatology, Geneva University Hospital, Geneva; ²Rheumatology, Neuchâtel Hospital, Neuchâtel; ³Orthopaedics and Traumatology, Geneva University Hospital, Geneva, Switzerland

Background: Although small observational studies have suggested that local corticosteroid (CS) injection may be effective in the management of the greater trochanteric pain syndrome (GTPS), no prospective placebo controlled study has been carried out to establish the efficacy of this common intervention.

Objectives: To perform a randomized double-blind placebo controlled trial to investigate the efficacy of local CS injection in the management of GTPS.

Methods: The trial was conducted in the Rheumatology unit of a University teaching hospital in Geneva, Switzerland. Inclusion criteria were lateral hip pain (LHP) for greater than 1 month, a LHP score of ≥ 4 in the preceding week, failure of another standard treatment (physiotherapy, analgesics, etc.) and typical LHP reproduced by palpation of the greater trochanter (GT). Participants were randomised in a 1:1 ratio to: 1) injection with a combination of local anaesthetic and CS (Treatment group), or 2) injection with normal saline solution (Placebo group). The Treatment group received 4ml of 1% Lidocaine (Rapidocain®) and 1ml of Bethametasone (Diprophos®). The Placebo group received 5ml of sterile saline solution. Injections were performed under ultrasound guidance. The study's predefined primary outcome of interest was the difference in pain intensity at 4 weeks post-injection between the 2 groups. Secondary outcomes included the number of "responders" (pain score improvement of ≥ 1.5) and the number of patients with low disease activity (LDA) (pain score ≤ 2.0). Patients were followed up for 6 months.

Results: A total of 46 patients were included and there were no significant differences between the 2 groups at baseline (Table 1). There were no significant differences between the 2 groups in terms of the reduction in pain at one month post-injection, with scores of -1.5 and -2.5 (p=0.23) in the Treatment and Placebo groups respectively. When including all measures in the first 3 weeks and using multilevel regression, there was a marginally significant improvement

Table 1. Baseline patient characteristics

	Active treatment (n=21)	Placebo (n=25)	p-value
Age (years) [SD]	56.6 [14.6]	59.6 [13.1]	0.46
Sex (% female)	81.0	88.0	0.51
Weight (kg) [SD]	74.4 [15.1]	74.7 [15.8]	0.95
Height (cm) [SD]	163.6 [7.7]	153.6 [32.5]	0.18
BMI [SD]	27.9 [6.1]	28.8 [4.9]	0.59
Pain over past 24 hours	6.1 [1.5]	6.6 [1.8]	0.29
Pain on palpation of GT	6.6 [2.0]	7.1 [1.9]	0.40
Pain injection of GT (% yes)	38.1	40.0	0.92
Oswestry total score [SD]	39.9 [13.1]	39.9 [14.9]	0.99
Womac pain score [SD]	251.4 [80.5]	247.2 [87.2]	0.87
Womac function score [SD]	414.6 [154.9]	366.1 [175.7]	0.33

Except where indicated otherwise, values are the mean ($\pm$ standard deviation). GT = greater trochanter region.