strengthen the EPF and EMSP's wider initiatives on tackling the multiple forms of discrimination faced by patients with chronic conditions.

The workshop demonstrated how many issues surrounding young people with chronic conditions transitioning into the labour market are still prevalent. The expectation of discrimination and stigma in the workplace, along with the unwillingness to disclose their condition when applying for a job for fear of rejection are confounded by young patients' experiences of negative employer attitudes. Moreover, the concept of quota systems and giving people with chronic conditions and/or disabilities preference among applicants for certain jobs possibly suggests that they are employed because they have a chronic condition and/or disability, not because of their abilities. This unambiguous form of positive discrimination also affects how young people manage information about their health. They feel forced to share about their condition to get an interview, however by doing so they risk being subjected to negative reactions in the interview or at the workplace. Young people with chronic conditions have a great deal to contribute to the workplace and more action should be taken to encourage and support employers with hiring them. Training and resources should be provided to managers and employees to raise awareness of the impact that chronic conditions can have on an individual, and how they can be assisted through small adjustments or specific care requirements. Employees should not assume what someone can or cannot do and how their condition affects them, therefore a place for an open discussion should be created. In addition, where quota systems apply, they should be re-evaluated and designed to recruit young patients on merit, in competition with other workers without a chronic condition and/or disability.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7262

SP0072 CHALLENGES AND POTENTIAL SOLUTIONS ABOUT STAYING IN WORK AS A YOUNG PERSON WITH AN RMD

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Introduction: A lot of young people with RMDs experience difficulties when it comes to staying in work after diagnosis. Some employers see a young person with an RMD-diagnosis as a liability. They are afraid it will cause a lot of difficulties with sick leaves and less work effort and in the end cost them a lot of money. Often the young person hasn't worked in the company for that many years (because of the age) and hasn't had the chance to make themselves indispensable/a valued work force yet, which makes it easy/obvious for the employer to terminate their employment.

The process of getting a diagnosis can often cause long periods of sick leave in the beginning and many employers don't understand that this will get better over time as the person gets used to having the disease and the medication has a chance to work properly.

Some young people choose not to tell their employer, that they have an illness at all, which can also be a big problem. When the employer and the work colleges don't know about the diagnosis, they cannot take special consideration to the person with the illness. Sometimes, you might a little extra break to be able to work an entire day and without it you risk wearing yourself down and having to quit the job yourself. If you choose to take the breaks yourself or perhaps fail at your job, because you try to do as much as the healthy persons, you risk getting fired, because nobody knows there is a good reason why you cannot do as much as you "should". Young and inexperienced persons can have difficulties demanding special treatment. They are often too insecure to stand their own ground and demand special consideration.

Objectives: I aim to examine the problems young people with RMDs face, when they want to stay in work and find potential solutions to these problems. How big is the problem? What can be done by the young people themselves? How can national patient organisations help them? How can EULAR PARE or other united European patient organisations help? Do we need new regulations? How do we make each country follow the EU-legislation?

Methods: I have asked young people with RMDs from all across Europe about their experiences with staying in work through social media and email. I have also asked patient organisations from all of Europe through email and personal meetings about their experiences, when it comes to young people with RMDs and work.

Results: The challenges differ from country to country. In some countries having an RMD is seen as a taboo, a sign of weakness. In other countries, an RMD-diagnosis makes you no different than the rest of society and the expectations to what you can do are often too high. I will attempt to make a presentation of potential solutions to the different issues. How it could help, if patient organisations spread awareness about RMDs among employers all across Europe. How, if the young person told their employer, that they have an RMD, it might help them in the long run. There are several places where young people with RMDs can get help and advice on how to act, when they want to stay in work. There already exists EU-legislation on the area, but not all EU-states respect them and adhere to them – this has to be changed.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7167

SP0073 PRACTICAL EMPLOYABILITY SUPPORT FOR YOUNG PEOPLE WITH RMDs

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Background: Arthritis Care is a UK national charity providing a range of support through three services;

Working Well with Arthritis - Joint Working employability service (Scotland only).

87% of Arthritis and Work Scotland 2016 survey respondents' state arthritis has a high or very high impact on work. Joint Working (JW) service aims to address this by:

Providing holistic employability support to individuals of working age to improve their capacity to manage their condition in work.

Providing employers support to increase understanding of arthritis within the workplace

Offering employers free Arthritis Awareness training.

Young People and Families Service (YPFS) for age 10 - 25 years.

Series of free, one day or weekend workshops, to help reduce social isolation, increase confidence and management of condition.

Living Well with Arthritis offers adults access to self management support such as:

Managing pain/symptoms; activity/exercise; health walks, Tai chi for arthritis; peer support.

Objectives: Joint Working (JW) service aims to help individuals of working age with arthritis make informed decisions about work, support them to remain in, return to, or explore suitable work, training or alternative employability opportunities.

1 in every 1,000 young people in the UK has arthritis, YPFS complements medical treatment by providing additional social and emotional support, to help reduce isolation and increase resilience. With all services being delivered by Arthritis Care there is a natural crossover and support network for young people around transitioning from education to work.

The services aim to provide individuals with the knowledge, confidence, skills and support to empower them to make informed life and work decisions and access key support services - with the aim of improving their chances of remaining in work.

Method: There is a partnership and referral process to JW via NHS Rheumatology Occupational Therapy staff, within specific NHS areas, though referral to JW is open to anyone with arthritis.

Partnership working with; NHS, employability networks and Arthritis Care YPFS is key to the success of JW service.

Individuals with arthritis often find; communicating their needs, understanding their rights and navigating the system can be complex and overwhelming.

Joint Working provides support through a range of mediums; 1 to 1 meetings (where practical), email and/or phone. Exploring areas of concern, improving understanding of rights, awareness of, and access to national employment support schemes, mainstream or disability employability services.

Results: Young people who have used Joint Working service have been supported to access a range of services; obtaining specialist equipment or travel support to remain in work, returning to work after many years unemployed, work placement to support university course, volunteering or specialist employability opportunities.

Conclusions: The employability interventions have positive psychosocial benefits, reducing feelings of isolation, increasing confidence and raising aspirations.

People with arthritis value the opportunity to discuss any issues they have remaining in, returning to or embarking on a career path.

The ongoing access to all Arthritis Cares services, ensure young people have a long-term support network.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.7149

THURSDAY, 15 JUNE 2017

Epidemiology of rheumatic and musculoskeletal diseases - a critical appraisal

SP0074 THE FUTURE OF EPIDEMIOLOGICAL RESEARCH IN RHEUMATIC AND MUSCULOSKELETAL DISORDERS

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Epidemiological research has gone through a very exciting time over the past years in rheumatic and musculoskeletal disorders (RMDs). The future is just as exciting. Although 'traditional' epidemiology in terms of prevalence and incidence of diseases is quite well-known now, there are many gaps to our knowledge in particular in the field of outcomes research (what to assess, when and how?) but also in the field of predictive factors (e.g. predictive factors of severity and of treatment response). Better knowledge in outcomes assessment is key to feasibility of standardised assessments and is the basis of shared decision making. Better knowledge of predictive factors will open the door to truly personalised medicine. Some future directions will be discussed in this talk.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7122

THURSDAY, 15 JUNE 2017

Ultrasound advanced I & II

SP0075 ULTRASOUND AND MAGNETIC RESONANCE IMAGING FUSION OF IMAGES EVALUATION OF TENOSYNOVITIS – A PILOT STUDY ON A NEW IMAGING TECHNIQUE IN RHEUMATOID ARTHRITIS PATIENTS

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Background/Purpose: Image fusion is an advanced imaging technology, which enables fusion of ultrasound (US) and magnetic resonance imaging (MRI). This fusion gives for each US probe position an exact projection of the corresponding anatomical area on a previously obtained MR image, during a live US assessment. This study is the first to address image fusion of US and MRI tenosynovitis.

The aim of this study was to assess and compare US and MRI visualisation of tenosynovitis using image fusion technique.

Methods: Fifteen rheumatoid arthritis patients with US verified tenosynovitis in the wrist or hand had an MRI performed of the affected wrist or hand. A subsequent image fusion was performed, i.e. the MR images and a live US assessment of one tendon sheath were fused. In order to compare the two imaging modalities quantitatively, the area of the tendon and tendon sheath in the transverse axis was measured on US and MRI for each image fusion. Due to partial volume artefacts (voxel containing two different tissues and therefore possessing a signal average of tendon and tendon sheath) on MRI two measures were performed; area 1) the circumference of the black tendon, i.e. excluding voxels containing two types of tissue 2) the circumference of the grey line that surrounds the black tendon, i.e. including voxels containing two types of tissue. Tenosynovitis was assessed using the proposed OMERACT semi-quantitative scoring system for US and MRI. US scoring was therefore based on both grey scale and Doppler, whereas MRI scoring was based only on post-contrast tenosynovial enhancement, measured as distance from the tendon to end of the enhanced tendon sheath.

Results: The median circumference area of the tendons and tendon sheaths on US and MRI 1 and 2 were respectively 0.16 (25;75 pctl: 0.10;0.25), 0.9 (0.06–0.18) and 0.13 of (0.10;0.25) for the tendons and 0.18 (0.13–0.26), 0.27 (0.20–0.45) and 0.23 (0.16–0.40) for the tendon sheaths. Statistically significant differences were found for all measured areas between US and MRI, except for the US tendon area and the MRI tendon area 2 (Wilcoxon's test; $p=0.47$). Overall agreement between US and MRI tenosynovitis scoring systems was good (see table 1).

Conclusion: In conclusion, we found that US and MRI have good agreement for quantitative assessment of tendons and scoring of tenosynovitis, when comparing the two modalities using image fusion, if the partial volume artefacts on MRI are included in the measure.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7204

SP0076 HOW AND WHEN TO ASSESS THE CERVICAL FACET JOINTS + DEMO

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At any given time, 10% of the adult population will be affected by neck pain. Although similar in incidence to low back pain, it has less of a socio-economic impact and uncommonly progresses to neurologic deficit. Pain may result from degenerative, traumatic or inflammatory processes involving the diarthrodial facet (zygapophyseal) joints and/or the facet (medial branch of the dorsal dorsal rami) nerves. Although routinely evaluated by radiography, magnetic resonance imaging and computed tomography, high-resolution musculoskeletal ultrasound (MSKUS) imaging and guidance has become increasingly popular, particularly among pain management specialists, in the evaluation and treatment of these structures owing to its safety, portability, superior resolution and direct real-time visualization. This presentation will discuss the unique anatomy and sonoanatomy of the cervical spine and its innervation/vascularization with particular focus on the facet joints and nerves and the use of MSKUS in the evaluation and treatment of the facet joint/nerve with review of available evidence. Examination technique and sonoanatomic findings will be demonstrated.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7170

SP0077 HOW TO EVALUATE JOINTS IN JUVENILE IDIOPATHIC ARTHRITIS (JIA)

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Ultrasound (US) has numerous advantages when used to examine joints in children compared to other imaging modalities. This include non-invasiveness, rapidity of performance, easy repeatability, high patient acceptability and lack of exposure to ionizing radiation. In addition, it does not require sedation for scanning in younger children. US is more sensitive than physical examination and may detect early disease that is not evident on physical examination. Lack of standardized precise definitions of grey scale (GS) and Power Doppler (PD) US findings in different age groups was the biggest limitation for its use. Additional difficulty is age dependent variability of normal sonoanatomy, due to maturation and ossification in children. That is why acquisition, interpretation and comparison of US images are completely different than in adults and had to be addressed specifically. All this may affect the validity of the technique, and without defined standardized examination technique, US can be a challenge in the childhood population. On the other hand, US as an imaging technique is considered to be examiner and equipment dependent. Studies resulting in good intra and inter-reader reliability and validity, based on specific definitions, are essential for its application as a diagnostic tool. Recently developed standardized image acquisition methodology, definitions of joint components in healthy children, as well as, definitions for synovitis components and its grading in GS and PD in children will be presented in details.

US allow precise and thorough visualization of inflammatory and destructive joint abnormalities, including synovial hyperplasia, joint effusion, cartilage damage, bone erosion, tenosynovitis and enthesopathy. In JIA ultrasound is considered particularly useful for its ability to detect subclinical synovitis and improve classification of JIA patients into the subtypes. Current evidences about application of ultrasound in JIA can improve definition of remission necessary to optimize treatment strategies. Due to peculiarities of US examination and image acquisition in children additional educational efforts among pediatric rheumatologists are required for expanding this imaging modality in daily practice.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7186

THURSDAY, 15 JUNE 2017

PsA: an integrated perspective

SP0078 CAN IMAGING BE A PREDICTOR OF PSORIATIC DISEASE?

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Early detection of inflammatory joint diseases is very important to allow prompt initiation of effective therapies. Identifying patients with early arthritic disease can be challenging by conventional clinical, laboratory and radiographic methods, and more advanced imaging modalities such as computed tomography (CT), magnetic resonance imaging, ultrasonography (US) and various nuclear medicine techniques can provide additional information.

This talk describes the current knowledge on the value of different imaging modalities for 1) predicting development of psoriatic disease in undifferentiated patients 2) predicting development of psoriatic arthritis (PsA) in patients with psoriasis with and without musculoskeletal pain and 3) predicting the disease course in patients with PsA.

Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7188

SP0079 PATHOLOGIES ACROSS THE TISSUES IN PSA

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The psoriatic disease concept includes the skin disease psoriasis and joint disease psoriatic arthritis. Increasingly, prevalent comorbidities such as obesity and cardiovascular disease are considered to be an integral part of the psoriatic disease concept in many patients.

Within this disease concept, accumulating evidence indicates molecular and cellular cross talk between affected organs and tissues. Skin inflammation affects the bone; nail disease is associated with specific types of arthritis; inflammation links to cardiovascular disease; skin or joint disease may contribute to depression. Novel therapeutic strategies are reaching psoriatic disease patients as never before. Their global impact could be envisioned from a holistic perspective, optimizing the strategy chosen as determined by the active molecular and cellular network that triggers and sustains disease.

Thus, linking the joints with the skin and other organs involved is proposed as an entry point towards personalized medicine in a complex disease.

Disclosure of Interest: R. Lories Grant/research support from: Celgene, Boehringer-Ingelheim, UCB, Consultant for: Janssen, Celgene, Novartis, Pfizer, UCB, Abbvie, Speakers bureau: Janssen, Celgene, Novartis, Pfizer, Merck, UCB, Abbvie