isokinetic muscle strength assessment, hand grip strength and gait speed had predictive values for sarcopenia.

**Abstract SAT0577 – Table 1.** Baseline features of the patients of knee Osteoarthritis and healthy controls

<table>
<thead>
<tr>
<th></th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>67.06±2.02 (64-69)</td>
<td>60.24±4.71 (50-70)</td>
<td>59.76±3.19 (52-69)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Body mass index</td>
<td>22.96±3.34</td>
<td>23.82±5.44</td>
<td>22.93±2.40</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mid Upper Arm Circumference</td>
<td>22.13±4.00 (18-32)</td>
<td>23.35±0.24 (21-32)</td>
<td>23.18±0.43 (21-32)</td>
<td>0.976</td>
</tr>
<tr>
<td>Calf circumference</td>
<td>31.81±2.28 (25-30)</td>
<td>30.56±3.32 (22-39)</td>
<td>25.80±5.46 (21-37)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hand girth</td>
<td>09.09±4.00 (7-11)</td>
<td>10.12±1.04 (8-3)</td>
<td>0.60±1.04 (0.36-0.69)</td>
<td>0.589</td>
</tr>
<tr>
<td>Hand grip strength (right)</td>
<td>13.56±2.04 (11-15)</td>
<td>25.05±6.95 (9-38)</td>
<td>21.94±3.72 (10-39)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Conclusions:** We found that patients with sarcopenic OA were older, weaker, less powerful, undernourished, and restricted in their level of physical activity in the study in which we identified sarcopenia as approximately 12% in patients with osteoarthritis. Among the methods of determining sarcopenia, ultrasound becomes prominent with its practical, cheap and easily accessible features. We think that our results will increase the awareness of the presence of sarcopenia in OA patients.

**REFERENCES:**


**Disclosure of Interest:** None declared

**DOI:** 10.1136/annrheumdis-2018-eular.7043

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**RESULTS:** 20% of participants had bone signal and/or erosion at PTE. Cross-sectionally, presence of PTE abnormalities were associated with greater intensity of pain while going up and down stairs (p<0.02 (95% CI: 0.03, 0.41)), greater risk of having a femoral BML (RR=1.46 (1.22, 1.90)), greater lateral tibial bone area (p=25.95 (1.00, 50.91)), smaller IPFP area (p=0.26 (0.46,-0.05)), and a worse tibial cartilage defect cross sectionally (RR=1.70 (1.16, 2.47), after adjustment of demographic and structural confounders. Longitudinally, PTE abnormalities at baseline predicted an increased risk of deleterious changes in tibial BML size (RR=1.52 (1.12, 2.05)) but not clinical symptoms, and other structural changes over 10.7 years.

**Conclusions:** Patellar tendon enthesis abnormalities are common in the elderly. The presence of cross-sectional but not longitudinal associations suggests they commonly co-exist with other knee structural abnormalities, but that they are not a major player in symptom development or structural changes, excepting tibial BMLs.

**REFERENCES:**


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**RESULTS:** Patients with sarcopenic OA were older, weaker, less powerful, undernourished, and restricted in their level of physical activity in the study in which we identified sarcopenia as approximately 12% in patients with osteoarthritis. Among the methods of determining sarcopenia, ultrasound becomes prominent with its practical, cheap and easily accessible features. We think that our results will increase the awareness of the presence of sarcopenia in OA patients.

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**RESULTS:** Autoantibodies directed against post-translationally modified proteins, such as citrullinated (ACPA) and carboxylated (anti-CarP antibodies) proteins, are a hallmark of rheumatoid arthritis (RA), and are associated with more severe joint damage and inflammation. Interestingly, these antibodies are present in a small subset of SLE patients as well, in which they associate with bone erosions. This suggests the possible involvement of autoantibodies in inflammation and joint damage in other conditions than RA. Therefore, we hypothesised that autoantibodies are present in HOA and associate with erosive disease.

**Objectives:** To investigate whether three RA-associated antibodies, Rheumatoid Factor (RF), ACPA and anti-CarP antibodies, are present in hand OA and associate with erosive OA.

**Methods:** Anti-CarP IgG, ACPA IgG and RF IgM were measured by ELISA in baseline sera of HOA patients from 3 cohorts: HOSTAS (n=510, mean age 61.0 years, 85.7% women, 27.2% EOA), ECHO (n=47, mean age 63.4 years, 89.4% women) and EHOA (n=23, mean age 57.1 years, 73.9% women), and in sera of healthy controls (HC; n=196, mean age 44.1 years, 51.0% women). The prevalence of autoantibodies was compared between HOA and HC and between erosive and non-erosive HOA. In HOSTAS, hand radiographs were scored (Kellgren-Lawrence, OARSI osteophyte and joint space narrowing scores) and C-reactive protein (CRP) levels, representing inflammation, were assessed. Groups were compared using non-parametric tests.

**Results:** In both ECHO and EHOA cohorts, only one patient was positive for RF IgM and none were positive for ACPA IgG. In all three cohorts, a low prevalence of anti-CarP IgG was detected and this was not different between HOA patients and HC (6.6% vs. 3.6%, p=0.12). Moreover, in HOSTAS, the prevalence of all tested autoantibodies was low and not significantly different from HC (anti-CarP 7.1% vs 3.6%, p=0.08; ACPA 0.8% vs 1.5%, p=0.37; RF 8.1% vs 4.1%, p=0.30). Likewise, no difference was found between erosive and non-erosive HOA (anti-CarP 7.2% vs 7.1%, p=0.94; ACPA 0.7% vs 0.8%, p=0.92; RF 4.3% vs 6.5%, p=0.38). Radiographic damage and CRP levels were similar in anti-CarP positive vs negative, and RF positive vs negative HOSTAS patients.