size and frequency of SJU BME as defined by the Aarhus scoring module, were compared across clusters.

Results: MCA and cluster analysis revealed 3 clusters. Cluster 1 was predominantly HLA-B27 positive (96.7%) with SJU BME in half of the cases. Cluster 2 and 3 had SJU BME in all cases. Cluster 3 had fewer features suggestive of axSpA than clusters 1 and 2. There were significant differences in frequency (3.0 vs 2.0 vs 1.0) and extent of BME (4.0 vs 2.0 vs 1.0) across clusters 1, 2 and 3.

Abstract THU0240 – Table 1. Cluster-wise comparison of the construction variables, frequency and size of sacroiliac joint bone marrow oedema

Conclusions: Three clusters were identified among LBP patients with findings suggestive of axSpA: 1 predominantly HLA-B27 positive cluster with SJU BME in half of the subjects, and 2 clusters having less features suggestive of SpA and with SJU BME in all subjects. The predominantly HLA-B27 positive cluster had more and larger BME lesions than the other 2, which may indicate individuals at risk for progression.

REFERENCES:

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THU0241 MUSCULOSKELETAL INVOLVEMENT IN INFLAMMATORY BOWEL DISEASE PATIENTS: A MONO CENTRIC EXPERIENCE

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Background: Musculoskeletal symptoms are frequently reported by patients with inflammatory bowel diseases (IBD). Those symptoms may vary from arthralgia to arthritis, involving peripheral or axial joints, with a prevalence ranging from 17% to 62% when considering any SpA manifestation (with a similar range for axial or peripheral involvement from 5% to 30%) and a definite SpA diagnosis up to 46%. To date, a more comprehensive approach is needed, also because the use of DMARDs or biologics could improve both gastrointestinal and musculoskeletal symptoms.

Objectives: To evaluate the rate of MSK involvement in a mono centric cohort of IBD patients.

Methods: A questionnaire based on the features of SpA was used in the IBD out-patient clinic from January 1st to December 31st 2017. When there was a positivity for any feature, the patients were evaluated by a rheumatologist (with more than 18 years of experience in SpA). At the visits were performed in 2–3 weeks from the moment the questionnaire was performed (varying according to the seasonal time for holidays). When there were some doubts about the diagnosis, further examinations were requested.

Results: A total of 403 patients were visited in the out-patient clinic (220 affected by CD, 172 affected by UC and 11 with a not defined IBD). Fifty-nine patients were sent to the rheumatologist (33 CD, 24 UC and 2 not defined IBD). Eleven patients had 2 or more rheumatologic features (to follow-up the disease and check the results of the exams required). To allow a diagnosis, 4 sacroiliac joints MRI and 1 ultrasound assessment of the feet were requested. A diagnosis of peripheral SpA was made in 9 patients while axial SpA was diagnosed in 7 subjects. The diagnosis was fibromyalgia, osteoarthritis and arthralgia in 1, 2 and 40 patients, respectively. Therapy was modified in 16/59 patients after the rheumatologic assessment (DMARDs were prescribed in 12 subjects while anti-TNFα in 4 of them). In 1 patient (with absolute contraindication for biologic therapy), two courses of SI joint injection were performed, improving local pain.

Conclusions: The results of our study confirm the already published prevalence of musculoskeletal involvement in IBD patients (15% of our IBD population complained musculoskeletal pain and 27% of the patients sent to the rheumatologist were given an enteropathic arthritis diagnosis). As for the already existing literature, we did not notice any evident difference in the prevalence of axial and peripheral involvement. An established collaboration between gastroenterologists and rheumatologists is necessary to provide an integrated and more comprehensive management of IBD, improving the quality of life of the patients.