the sacroiliitis sum score of pelvic vs. AP lumbar radiographs. Inter-observer agreement for pelvic and AP lumbar radiographs was also good to excellent: ICC at baseline: 0.81 and 0.73, respectively, at year 2: 0.76 and 0.79, respectively. A total of 62 (54.9%) and 55 (48.7%) patients were classified as r-axSpA at baseline based on evaluation of pelvic and AP lumbar radiographs, respectively. The absolute agreement on the classification was 84.9% (figure 1). A total of 17 patients (12 (10.6%) with nr-axSpA and 5 (4.4%) with r-axSpA) were classified differently based on assessment of AP lumbar as compared to conventional pelvic radiographs (figure 1).

After 2 years of follow-up, progression from nr- to r-axSpA occurred in 7 patients (6.2%) and 8 patients (7.1%) classified as nr-axSpA at baseline based on pelvic or AP lumbar radiographs assessment, respectively. Regression from r- to nr-axSpA occurred in 4 patients (3.5%) and 3 patients (2.7%) on pelvic or AP lumbar radiographs, respectively, giving a respective net progression rates of 2.7% and 4.4%.

Abstract THU0274 – Figure 1. Classification as non-radiographic or radiographic axial spondyloarthritis based on sacroiliitis assessment on conventional pelvic and anteroposterior lumbar radiographs.

Conclusions: Radiographic sacroiliitis can be assessed on AP lumbar radiographs with a similar reliability as on conventional pelvic radiographs.

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THU0275

THE RELATIONSHIP BETWEEN MAASTRICHT ANKYLOSING SPONDYLITIS ENTHESITIS SCORE AND THE SPONDYLOARTHRITIS RESEARCH CONSORTIUM OF CANADA ENTHESITIS INDEX IN ANKYLOSING SPONDYLITIS: FRIENDS OR ENEMIES?

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Background: The enthesitis screening is critical for the diagnosis and for monitoring the disease activity in axial spondyloarthritis (AS). Several indices have been developed for the clinical evaluation of enthesitis, including the Maastricht Ankylosing Spondylitis Enthesitis Score (MASES) in 2003 and the Spondyloarthritis Research Consortium of Canada (SPARCC) in 2008. Each of them has advantages and limitations, but could they be complementary?

Objectives: The objective of our study was to compare the abilities of MASES and SPARCC in detecting enthesitis and to look for possible correlations between these two scores.

Methods: We designed this prospective study in 60 patients meeting modified New York criteria for AS and seen at the rheumatology department. All patients underwent a clinical evaluation, in which scores of MASES (range 0–13) SPARCC (range 0–16) and visual analogue scale (VAS) for enthesitis pain were recorded. Ultrasound scans were taken for five entheses sites on both sides in lower limbs (proximal and distal insertions of the patellar tendon, patellar insertion of the quadriceps tendon, and calcaneal insertions of the Achilles tendon and superficial plantar fascia).

Results: Sixty AS patients were enrolled (48 men and 12 women) with a mean age of 36 years^{20–74} and mean disease duration of 8.8 years [0.5–25]. Biological inflammation was detected in 51 patients with mean erythrocyte sedimentation rate (ESR) of 33^{2–98} and mean C reactive protein of 16.9 mg/L [0–240]. Physical examination found 77/600 painful entheses sites (12.8%), of which quadriceps and calcaneum entheses were the most painful in 16% and 15.8% cases respectively. The mean MASES was 3.4 [0–13] and the mean SPARCC was 2.98 [0–16]. A null MASES and SPARCC scores were recorded in 18 (30%) and 23 (38%) patients respectively. US imaging of the entheses showed peritendinous oedema and bursitis mainly at distal insertions of the patellar tendon in 51% and 55% respectively. Erosions were more likely detected at Achilles tendon site (95.8%). MASES and SPARCC scores were both significantly correlated with VAS for enthesitis pain ($r=0.52$; $r=0.46$; $p<0.0001$ respectively), with the BASDAI ($r=0.39$; $r=0.40$; $p<0.0001$ respectively), with BASFI ($r=0.45$; $r=0.39$; $p<0.0001$), with VAS for global pain ($r=0.55$; $r=0.51$; $p<0.0001$ respectively) and with ESR ($r=0.23$; $p=0.012$ for both). The sonographic score for acute enthesitis correlated only with the MASES, however overall sonographic score correlated only with the SPARCC (table 1). The MASES and SPARCC scores were positively correlated ($r=0.768$; $p<0.0001$).

Abstract THU0275 – Table 1. Correlations among clinical and sonographic scores.

Enthesitis indices	Sonographic score for acute enthesitis	Overall sonographic score	Sonographic score for chronic enthesitis	Doppler score
MASES	$r=0.24$ $p=0.008$	$r=0.114$ $p=0.2$	$r=0.14$ $p=0.12$	$r=0.1$ $p=0.27$
SPARCC	$r=0.15$ $p=0.09$	$r=0.198$ $p=0.030$	$r=0.17$ $p=0.05$	$r=0.12$ $p=0.18$

Conclusions: Good correlations were found between the 2 enthesitis indices in AS with special sonographic features for each, attesting their complementary relationship.

Disclosure of Interest: None declared

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THU0276

MRI LESION DEFINITIONS IN AXIAL SPONDYLOARTHRITIS: A CONSENSUS REAPPRAISAL FROM THE ASSESSMENTS IN SPONDYLOARTHRITIS INTERNATIONAL SOCIETY (ASAS)

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Background: There has been substantial progress in the characterisation of MRI lesions in the sacroiliac joints (SIJ) and spine in axial spondyloarthritis (axSpA) since the last consensus-based descriptive reports from ASAS^{1,2}. There is as yet a lack of international consensus on standardised definitions of all the lesions reported to date. Consequently, the ASAS MRI group was convened to generate a consensus update.

Objectives: To evaluate the literature describing the spectrum of MRI lesions in axSpA and to generate a consensus update on standardised definitions.

Methods: The literature pertaining to MRI lesion definitions in axSpA was discussed at 3 meetings of the ASAS MRI group attended by 26 investigators. The group reviewed the literature for MRI lesion definitions and decided by consensus which definitions would be retained, which required modification, and which required a new definition.

Results: For definitions denoting signs of activity in the SIJ, there are no revisions to the most current ASAS definition of a positive MRI¹. Definitions for capsulitis and enthesitis are revised. A new definition, *joint space enhancement*, denotes increased signal on contrast-enhanced images in the joint space of the cartilaginous portion of the SIJ. This replaces the term 'synovitis' and a separate definition describes what constitutes joint space fluid. For structural change in the SIJ, the definition for sclerosis is unchanged. Revised definition for a fatty lesion incorporates characteristics typical of axSpA, and for erosion requires both loss of cortical bone as well as adjacent marrow matrix. A new definition, *fat metaplasia in the joint space* ('backfill'), denotes the reparative change on a T1W image at the site of erosion when signs of activity recede. The new definition for ankylosis stresses the continuity of bright marrow signal across the joint space. Spinal lesion definitions are divided into those that occur in defined central and lateral sagittal slices. The revised definition of a vertebral corner inflammatory lesion divides this into a regular (type A) and dimorphic (type B) lesion. A new definition for corner erosion requires both loss of cortical bone as well as adjacent marrow matrix. New definitions for new bone growth require bright signal on T1W images extending from the vertebral corner marrow or endplate, which may (ankylosis) or may not (bone spur) be continuous with the adjacent vertebra.

Conclusions: The ASAS MRI group has generated a consensus based update on MRI lesions in axSpA.

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THU0277

WHICH MRI LESIONS IN THE SACROILIAC JOINT ARE ASSOCIATED WITH THE DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS AFTER 2 YEARS FOLLOW UP IN THE ECHOSPAC IN SPONDYLOARTHRITIS COHORT (ECHOSPAC)?

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Background: MRI of the sacroiliac joint (SIJ) is emerging as an important prognostic tool for assessment of patients presenting with SA and this may have consequences for early treatment. A major challenge in early SA is establishing the diagnosis and this requires prospective follow up to determine which cases have developed SA with more certainty. In addition, it is unclear which MRI lesions have prognostic capacity

Objectives: To assess the baseline distribution and prognostic capacity of MRI lesions in the SIJ of patients diagnosed with axSpA after 2 years follow up in the ECHOSPAC cohort.

Methods: Consecutive outpatients with age <50 years and symptoms >3 months suggestive of SpA (inflammatory back pain, peripheral arthritis or inflammatory arthralgia, enthesitis or dactylitis, uveitis with B27 positivity, a family history of SpA) were enrolled in the prospective French ECHOSPAC cohort study. The diagnosis of SpA was ascertained by an expert committee, blind to MRI evaluation, after at least 2 years of follow-up. MRI scans from 223 cases were available for evaluation by 2 readers and an adjudicator who assessed MRI lesions in the SIJ according to updated consensus definitions from the ASAS-MRI group. These were recorded in an ASAS consensus-derived eCRF that comprises global assessment (active and/or structural lesion typical of axSpA present/absent) and detailed scoring of individual lesions (SPARCC SIJ inflammation, SPARCC SIJ structural). Clinical, lab, and imaging variables associated with the diagnosis of axSpA at 2 years were first identified by univariate regression. A base model of all clinical/lab variables associated with axSpA was included as a group in multivariate logistic regression models that tested the independent association with MRI lesions.

Results: Mean age of the 223 cases was 39.6 (10.5) years, mean symptom duration was 2.5 (4.1) years, 49.5% were HLA-B27 + and 63.7% were female. Primary inclusion criterion was IBP in 53%, IA in 27%, ED in 9%, B27 +U in 8% and Fam in

4%. At 2 years follow up, 165 (74%) were deemed to have axSpA. In group comparisons (table 1) and univariate regression, both active and structural MRI lesions were associated with diagnosis of axSpA at 2 years (p=0.03, p=0.01, respectively). Age, B27, and psoriasis were the clinical variables associated with diagnosis of axSpA at 2 years in univariate analysis (all p<0.0001) and were included together with gender in multivariate analyses. Active and structural lesions typical of axSpA and SPARCC BME score ≥2 were each independently associated with diagnosis of axSpA at 2 years (OR(95% CI)- 6.8 (1.4–34.1) (p=0.02); 17.9 (2.2–146.6) (p=0.007); 4.9 (1.3–18.4) (p=0.02). With all variables simultaneously added to the model, only structural lesions were significantly associated.

Abstract THU0277 – Table 1. Distribution of MRI lesions at baseline according to diagnosis of axSpA after 2 years

MRI Lesion	AxSpA n=165 (74.0%)	NOT SpA n=58 (26.0%)	P value
Active lesion typical for axSpA	26 (16.0%)	2 (3.6%)	0.019
Active lesion typical for axSpA (confidence ≥3, 0-4 scale)	18 (11.9%)	1 (1.8%)	0.027
ASAS MRI positivity	24 (14.6%)	1 (1.7%)	0.006
ASAS MRI positivity (confidence ≥3, 0-4 scale)	17 (10.8%)	1 (1.7%)	0.048
Structural lesion typical for axSpA	32 (19.6%)	1 (1.8%)	0.0004
Structural lesions typical for axSpA (confidence ≥3, 0-4 scale)	27 (17.3%)	0 (0%)	0.0002
Active AND structural lesion typical for axSpA	19 (11.7%)	0 (0%)	0.004
Active OR structural lesion typical for axSpA	39 (23.9%)	3 (5.4%)	0.001
Only active lesion typical of axSpA	7 (4.3%)	2 (3.6%)	1.0
Only structural lesion typical of axSpA	13 (8.0%)	1 (1.8%)	0.12

Conclusions: Assessment of both active and structural lesions on MRI may help determine which patients have axSpA with higher diagnostic certainty over time.

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THU0278

SERUM CALPROTECTIN IS CORRELATED WITH DISEASE ACTIVITY IN EARLY AXIAL SPONDYLOARTHRITIS BUT DOES NOT PREDICT RADIOGRAPHIC PROGRESSION AT 2 YEARS: RESULTS FROM THE DESIR COHORT

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Background: Calprotectin (S100A8/A9), a protein secreted by activated neutrophils and monocytes in inflammatory conditions, is upregulated in active spondyloarthritis¹ and associated with radiographic spinal progression in axial spondyloarthritis (axSpA)²

Objectives: To determine if serum calprotectin level at baseline can predict the radiographic progression of structural damage in spine at 2 years in the early axSpA cohort DESIR (DEvenir des Spondyloarthrites Indifférenciées Récentes) and to compare the association with spine and sacroiliac joint (SIJ) inflammation on magnetic resonance imaging (MRI).

Methods: Patients presenting with inflammatory back pain suggestive of axSpA for less than 3 years from the DESIR cohort were analysed. axSpA patient were defined as patients who fulfilled the Assessment in SpondyloArthritis Society (ASAS) criteria for axSpA at baseline. Calprotectin was assessed in the serum at baseline with ELISA kit (Hycult Biotech, the Netherlands). Spine radiographs, SIJ and spine MRI were centrally scored. Radiographic spinal progression was defined as worsening by ≥2 units of the mSASSS 2 years after the inclusion. Level of MRI spine and SIJ inflammation at baseline and 2 years was evaluated with BERLIN and SPARCC score. The associations between calprotectin level and mSASSS worsening were tested with Wilcoxon test, Berlin and SPARCC score were tested by Spearman's correlation tests.

Results: Of all, 426 had a calprotectin dosage and an early axSpA according to the ASAS criteria. Among them, 211 patients have had a mSASSS scoring at baseline and M24. A total of 399 patients have had spinal and SIJ MRI scoring at baseline. Only 15 patients had a radiographic progression with a variation of mSASSS ≥2. We showed a correlation between baseline calprotectin and MRI inflammation in SIJ or spine (Berlin score (r=0.15, p=0.003), SPARCC Sacroiliac score (r=0.12, p=0.012) and SPARCC Spine score (r=0.16, p=0.002)). Calprotectin baseline level was significantly higher in patients who fulfilled axSpA ASAS sacroiliitis arm criteria versus those who fulfilled ASAS HLA B27 arm criteria without any signs of sacroiliitis or versus patients did not fulfil ASAS criteria