	Inflammation (standard 6 slices)		Inflammation ("all slices")		Inflammation (extra slices in "all slices" not part of 6 slices)	
	Scores	ICC(3,1)	Scores	ICC(3,1)	Scores	ICC(3,1)
Status score at baseline	13 (6-21; 0-49)	0.81/0.77/0.84	14 (6-23; 0-49)	0.84/0.77/0.86	1 (0-3; 0-19)	0.65/0.53/0.73
Status score at week 52	2 (0-4; 0-12)	0.67/0.70/0.50	2 (0-5; 0-13)	0.62/0.69/0.46	0 (0-1; 0-2)	0.19/0.65/0.20
Change score (baseline to week 52)	-12 (-20 to -3; -45 to 5)	0.84/0.81/0.87	-13 (-26 to -4; -64 to +7)	0.86/0.79/0.90	-1 (-3 to 0; -19 to 1)	0.61/0.54/0.74
	Fat metaplasia (standard 5 slices)		Fat metaplasia ("all slices")		Fat metaplasia (extra slices in "all slices" not part of 5 slices)	
	Scores	ICC(3,1)	Scores	ICC(3,1)	Scores	ICC(3,1)
Status score at baseline	3 (0-10; 0-38)	0.89/0.64/0.81	4 (1-12; 0-48)	0.92/0.63/0.77	0 (0-2; 0-10)	0.80/0.40/0.49
Status score at week 52	7 (2-14; 0-35)	0.81/0.53/0.77	9 (2-19; 0-51)	0.87/0.57/0.70	1 (0-4; 0-16)	0.70/0.53/0.55
Change score (baseline to week 52)	1 (0 to 4; -4 to 18)	0.75/0.26/0.47	2 (0 to 3; -5 to 26)	0.84/0.34/0.46	0 (0 to 1; -1 to 8)	0.60/0.44/0.46
	Erosion (standard 5 slices)		Erosion ("all slices")		Erosion (extra slices in "all slices" not part of 5 slices)	
	Scores	ICC(3,1)	Scores	ICC(3,1)	Scores	ICC(3,1)
Status score at baseline	7 (1-11; 0-18)	0.70/0.66/0.73	8 (1-14; 0-23)	0.74/0.67/0.70	1 (0-2; 0-6)	0.45/0.18/0.62
Status score at week 52	3 (1-6; 0-16)	0.43/0.39/0.75	4 (1-8; 0-18)	0.42/0.38/0.69	1 (0-2; 0-6)	0.20/0.09/0.40
Change score (baseline to week 52)	-2 (-5 to 0; -11 to 1)	0.25/0.23/0.60	-3 (-6 to 0; -13 to 0)	0.23/0.29/0.37	0 (-1 to 0; -3 to 1)	0.03/0.05/0.29
	Backfill (standard 5 slices)		Backfill ("all slices")		Backfill (extra slices in "all slices" not part of 5 slices)	
	Scores	ICC(3,1)	Scores	ICC(3,1)	Scores	ICC(3,1)
Status score at baseline	0 (0-3; 0-11)	0.53/0.82/0.60	0 (0-3; 0-13)	0.48/0.79/0.63	0 (0-0; 0-2)	0.08/0.40/0.50
Status score at week 52	3 (1-5; 0-16)	0.26/0.44/0.75	4 (1-6; 0-18)	0.23/0.43/0.71	0 (0-1; 0-4)	-0.01/0.28/0.44
Change score (baseline to week 52)	1 (0 to 3; -7 to 9)	0.33/0.41/0.66	2 (0 to 4; -9 to 11)	0.35/0.40/0.74	0 (0-1; -2 to 3)	0.01/0.22/0.58
	Combined erosion and backfill (standard 5 slices)		Combined erosion and backfill ("all slices")		Combined erosion and backfill (extra slices in "all slices" not part of 5 slices)	
	Scores	ICC(3,1)	Scores	ICC(3,1)	Scores	ICC(3,1)
Status score at baseline	10 (2-13; 0-18)	0.68/0.67/0.73	12 (2-16; 0-24)	0.70/0.68/0.73	1 (0-3; 0-7)	0.52/0.31/0.66
Status score at week 52	8 (3-13; 0-20)	0.57/0.69/0.78	10 (4-14; 0-24)	0.61/0.71/0.79	1 (0-3; 0-8)	0.46/0.36/0.71
Change score (baseline to week 52)	-1 (-3 to 0; -7 to 4)	0.22/0.18/0.45	-1 (-2 to 0; -10 to 3)	0.18/0.25/0.30	0 (-1 to 0; -3 to 2)	0.09/0.09/0.40

Scores reported as median (IQR; range). ICCs are ICC(3,1), single rating, agreement, in pairwise comparisons (SK-UW/GK-UW/SK-GK). N = 53 for status score at baseline; N = 46 for status score at week 52 and change score/baseline to week 52.

Conclusions: The standardised 6/5 slices SPARCC methods had equal reliability as compared to evaluation of all cartilaginous slices. There was limited reliability to identify the posterior slice in the "all slices" approach, as opposed to good reproducibility to determine the transitional slice in the "6/5 slices" approach. Combining erosion and backfill scores tended to result in superior reliability compared to the 2 lesions separately, indicating a challenge to identify the transition from erosion to backfill.

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Disclosure of Interest: None declared

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FRI0593 MANTOUX TEST IS INADEQUATE TO DEFINE ALL SUBJECTS WITH LATENT TUBERCULAR INFECTION

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Background: Latent TB infection (LTBI), defined as 'a state of persistent immune response to *Mycobacterium tuberculosis* without clinically-manifested disease', inflicts a third of the world's population and nearly 10% of LTBI positive persons develop TB within 2-5 years. The tuberculin skin test (TST) and, more recently, interferon gamma release assays (IGRAs) are most commonly used for detection of LTBI. However, in a high TB burden setting such as India, both the assays have been found to grossly underestimate the true prevalence of LTBI, since almost equal number of new TB cases emerged from the test-positive and test-negative groups during the follow-up¹.

Objectives: This study was aimed at exploring whether an *in vitro* CD3 +T cell response to PPD can complement the *in vivo* TST response for the determination of true prevalence of LTBI in healthy Indians.

Methods: In this ongoing study, 80 apparently healthy workers (age 19-61 years) at SGPGIMS have been recruited. Their demographic data, including BCG vaccination status and duration of contact with TB patients, was recorded. TST was performed with 5 TU of PPD. Blood T cell (CD3+) responses to PHA (a mitogen, used as positive control) and PPD were determined by flow cytometry in terms of expression of the proliferation-induced nuclear protein Ki67.

Results: 48% of the study subjects showed positivity for TST (skin induration ≥ 10 mm) and the size of reaction could be correlated with age. There was no association between BCG vaccination status and TST positivity. 72% of the TST positive and 62% of TST negative persons showed positivity for CD3 +T cell response to PPD. Positivity for either assay was found to be 82%.

Conclusions: By combining TST with CD3 +T cell responses, the positivity for PPD was enhanced from 48% (TST alone) to 82%. Therefore, both the assays could be considered as complementary. It remains to be seen whether these assays, either singly or jointly, show a correlation with the emergence of TB in our study population during the follow-up.

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FRI0594 RETROCALCANEAL BURSITIS PRECEDES OR ACCOMPANIES ACHILLES TENDON ENTHESTITIS IN THE EARLY PHASE OF RHEUMATOID ARTHRITIS

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Background: We had reported the frequencies of various pathologies detected by ultrasound (US) in symptomatic ankles and heels in rheumatoid arthritis (RA) patients¹. Through that study, we recognised that Achilles tendon (AT) involvement is not rare in RA, because retrocalcaneal bursitis (RCB), AT enthesitis, AT tendonitis and AT paratendonitis was detected in 27%, 22%, 13%, and 6% of the symptomatic ankles examined, respectively. Recently, it has been reported that RA and SpA patients did not differ in enthesal abnormalities seen on US². However, we think that there is fundamental difference between the inflammation of synovio-enthesal complexes in RA and that in SpA.

Objectives: This study aims to investigate characteristics of enthesal abnormalities in RA by evaluating the association between US-detected RCB or AT enthesitis and clinical data.

Methods: We reviewed consecutive records of 100 ankles in 74 RA patients (filling the 2010 criteria) who underwent US examination of symptomatic ankles because of clinical need. The patients consist of 52 women and 22 men (median age 63.3 years, range 26-83 years) with median disease duration of 4.2 months (range 0.23 months to 19.4 years), as described previously. 55/74 (74%) of them were positive for RF and/or ACPA. The association between presence of RCB or AT enthesitis in a narrow definition (i.e., insertional tendinitis) and clinical data were analysed using Fisher's exact test or Mann-Whitney U test.

Results: Among the overall 100 ankles, the frequency of RCB-positive/AT enthesitis-negative ankles, that of RCB-positive/AT enthesitis-positive ankles and that of RCB-negative/AT enthesitis-positive ankles were all more than 10%. Interestingly, the frequency of RCB-negative/AT enthesitis-positive ankles among the 62 ankles with early RA (disease duration <6 months) was significantly lower as compared to that among the 38 ankles with established RA ($p=0.00595$). Similarly, the frequency of RCB-negative/AT enthesitis-positive ankles among the 58 ankles of untreated patients was lower as compared to that among the 42 ankles of already-treated patients. The disease duration was significantly longer in the RCB-negative/AT enthesitis-positive ankles than in the rest of the ankles (43.8 ± 74.6 months vs. 16.7 ± 35.3 months, $p=0.0179$).