criteria and individual IBP parameters(1). Performance of IBP in other countries is less studied.

Objectives: What is the diagnostic utility of IBP and the individual IBPpar according to the ASAS IBP criteria in several rheumatology settings in West- and Northern-Europe?

Methods: Data of the multicentre, observational Be-Giant and SPondyloArthritis Cause Early (SPACE) cohorts were used. The Be-Giant cohort included ≥ 18 years old, newly diagnosed axSpA pts who were diagnosed by a rheumatologist and fulfilled the ASAS axSpA criteria. SPACE cohort included pts, ≥ 16 years, with (almost) daily CBP for ≥ 3 months and ≤ 2 years, with a symptom onset < 45 years. In SPACE, axSpA pts were diagnosed by a rheumatologist (plus a level of confidence of ≥ 7 on a 0–10 scale). All other pts in SPACE were labelled as 'no axSpA'. Pts underwent a diagnostic workup according to the protocol of the corresponding cohort, including data on the individual parameters of the ASAS IBP criteria. Sensitivity, specificity and positive likelihood ratios (LR+) were calculated using the axSpA pts from each cohort separately and the "no axSpA" pts as control group.

Results: IBPpar data was available in 661 pts (SPACE) and 228 pts (Be-Giant); 36.0% and 49.6% were male, mean age 30.8 ± 8.2 and 34.7 ± 9.7 years, respectively. The figure shows a majority of axSpA pts with > 2 IBPpar, but this is also seen in the no axSpA pts. IBPpar show high sensitivity but very low specificity with 'pain at night' as exception with a slightly better specificity. LR+ were, in both cohorts, much lower (figure) than the LR+ of 3.1 for IBP previously reported as diagnostic estimate in routine practice.

Conclusion: IBP and the individual IBPpar are commonly seen in patients with and without an axSpA diagnosis. Our data confirm results from Germany, showing that the diagnostic utility of IBP in a rheumatology setting is lower than previously assumed with a (very) low specificity and LR+. It seems the distinctive impact of IBP is expressed when physicians refer their patient to the rheumatologist.

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SAT0312 GENDER CONTRASTS IN PATIENT REPORTED OUTCOMES DON'T ALTER THE DISEASE ACTIVITY SCORE IN AXIAL SPONDYLOARTHRITIS PATIENTS

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Background: Disease activity in axial spondyloarthritis (axSpA) is often quantified by the Axial Spondyloarthritis Disease Activity Score (ASDAS), a composite index which combines 4 patient reported outcome (PRO) parameters and C-reactive protein (CRP) as an acute phase reactant. ASDAS commonly acts as a target in treat-to-target approaches in axSpA patients.

Objectives: To identify the impact of gender on ASDAS in newly diagnosed axSpA patients and to determine whether possible differences are PRO- or CRP-driven.

Methods: Patients originate from the Be-Giant cohort, a Belgian observational registry of newly diagnosed axSpA patients (expert opinion). Included patients fulfill the Assessment of SpondyloArthritis international Society (ASAS) classification criteria for axSpA and are anti-TNF naïve prior to inclusion. An extensive patient description was performed at baseline, including PRO and laboratory investigations with CRP (mg/L). ASDAS was calculated for each patient and subdivided in a PRO-component (ASDAS-PRO) and a CRP-component (ASDAS-CRP) (1).

Results: By January 2019, 291 axSpA patients were included (138 male, 153 female). At baseline, ASDAS could be calculated in 262 patients. ASDAS-PRO was significantly higher in women compared to men (1,66 vs. 1,48, $p = 0,04$), while ASDAS-CRP did not differ significantly (0,90 for both genders, $p = 0,96$). No significant difference was found between the total ASDAS of women and men (2,54 vs. 2,38, $p = 0,09$) (Figure 1). When categorizing the score into 4 disease activity states (2), 60,8% (76/125) of men show high or very high disease activity (ASDAS > 2.1) at baseline compared to 67,2% (92/137) of women ($p = 0,35$).

Concerning the 5 ASDAS components, the discrimination between male and female axSpA patients was most pronounced for *patient global* scores (Figure 2). Men reported a baseline patient global score of 4,3 (95% CI 3,8 – 4,8), compared to a score of 5,1 (95% CI 4,7 – 5,6) in women ($p = 0,01$).

Conclusion: Female axSpA patients report a significantly higher *patient global* score compared to men. This contributes to a significantly higher ASDAS-PRO in women. However, neither the ASDAS itself nor the ASDAS disease activity categories are significantly affected by gender contrasts in PRO.

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Figure 1. Total ASDAS score (ASDAS-TOT), subdivided in a PRO-component (ASDAS-PRO) and a CRP-component (ASDAS-CRP) in male and female axSpA patients.

Figure 2. Patient global score in male and female axSpA patients.

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