SIJ), SIJ only BMO score, erosions, sclerosis and fat scores were higher in the HLA-B27 positive group as seen in Figure 1, with only differences in the erosion (P=0.002) and sclerosis score (P=0.038) being statistically significant.

Abstract AB0727 Figure 1

Less active (BMO) and structural lesions were seen in the biologic treated group, reaching statistical significance in total BMO (P=0.041), erosions (P=0.039), fat (P=0.003) and sclerosis (P=0.013) scores. A clinical diagnosis of axial SpA was made in 42/119 (35%) cases. Of these, n=25/42 had BMO (SIJ or spine) and structural lesions. Structural lesions alone were evident in 13/42 of these cases. BMO lesions alone with no structural changes was found in 2 cases (grade 1).

Conclusion: MRI findings of sacroiliitis and spinal involvement, defined as a combination of active and structural lesions, are common in IBD subjects with symptomatic back pain. The low prevalence of BMO seen in this cohort may represent partially treated disease. The addition of structural lesions to the current definitions of a positive MRI, may help with the diagnosis of axSpA. The presence of HLA-B27 positivity appears to define a more severe axial phenotype in IBD associated axSpA.

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AB0728 PREVALENCE AND SEVERITY OF CLINICAL AND IMAGING AXIAL SPONDYLOARTHRITIS IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE

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Background: Some patients with inflammatory bowel disease (IBD), such as ulcerative colitis (UC) and Crohn's disease (CD), develop spondyloarthritis (SpA). Inflammatory back pain (IBP) is one of the most important signs of axial SpA. However, changes in conventional radiography take a long time to appear as typical changes, such as erosion, sclerosis, or ankylosis. Magnetic resonance imaging (MRI) is useful for assessing axial involvement. High-quality imaging modalities can detect the inflammatory condition in the joints and entheses more sensitively than clinical assessment or conventional radiography.

Objectives: This study aimed to examine the clinical and imaging prevalence or severity of axial SpA in patients with IBD.

Methods: A total of 56 patients, including 39 with UC (19 males, 20 females) and 17 with CD (10 males, 7 females) were included. The Assessment of SpondyloArthritis international Society (ASAS) Expert Criteria were used to assess IBP. The criteria were fulfilled if at least four of five of the following questions were answered by "yes": (1) did your back pain start when you were aged 40 or younger?; (2) did your back pain develop gradually?; (3) does your back pain improve with exercise?; (4) do you find that there is no improvement in your back pain when you rest?; and (5) do you suffer from back pain at night, which improves upon getting up? Image evaluation was performed blindly by two readers. Conventional radiography was evaluated by the modified Stoke AS Spine Score (mSASSS) in the spine and the Grade of modified New York criteria (mNY) in the sacroiliac joints. In MRI, spinal and sacroiliac joints were evaluated by the Spondylo-arthritis Research Consortium of Canada (SPARCC) score.

Results: Among the 56 patients with IBD, 21 had IBP by clinical examination and 11 had pain in the sacroiliac joints. In conventional radiography, the average mSASSS score was 8.9 in patients with IBP and 6.5 in patients without IBP (p = 0.257). Eleven patients had bilateral Grade 2 or unilateral Grade 3 of the mNY, and three (27.3%) of these patients had sacroiliac pain and eight (17.8%) did not have sacroiliac pain (p = 0.477). In spine MRI, nine (42.9%) patients with IBP and nine (25.7%) patients without IBP had an SPARCC score of > 2 (p = 0.184). In sacroiliac MRI, one (9.1%) patient with sacroiliac pain and 12 (26.7%) patients without sacroiliac pain had an SPARCC score of > 2 (p = 0.216).

Conclusion: Even without clinical symptoms of SpA, significant inflammatory findings are detected by MRI. Imaging might be important, regardless of the presence or absence of clinical symptoms, in patients with IBD.

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AB0729 ASSESSING THE DIFFERENCES IN TIMES TO GENERAL PRACTITIONER PRESENTATION AND DIAGNOSIS, AND OUTCOMES FOR AXIAL SPONDYLOARTHRITIS PATIENTS IN DIFFERENT ETHNIC GROUPS

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Background: Axial spondyloarthritis (axial SpA) is a condition characterised by inflammatory back pain +/- extra-articular manifestations. There is a known delay to diagnosis¹. Management includes physiotherapy, non-steroidal anti-inflammatory drugs (NSAIDs) and biologic agents². The Luton & Dunstable University Hospital, UK Rheumatology department looks after an ethnically diverse population of patients with the condition.

Objectives: The objectives of this study were to compare time from symptom onset to General Practitioner (GP) presentation, time from symptom onset to diagnosis, and response to treatment between different ethnic groups.

Methods: 124 patients with an axial SpA diagnosis, according to the Luton & Dunstable University Hospital Infoflex database, were identified. 24 patients were excluded due to a peripheral spondyloarthritis diagnosis. A retrospective case note review of 100 case records was undertaken. A Microsoft Excel spreadsheet was used to analyse data.

Results: The mean age was 44 years. 64 (64%) patients were male and 36 (36%) were female. 48 (48%) and 27 (27%) patients were HLA-B27 positive and negative respectively. HLA-B27 status was not available for 25 (25%) patients. Ethnicity breakdown showed 58 White British patients; 12 Pakistani; 7 White Other; 6 Bangladeshi; 5 White Irish; 5 Asian; 4 Indian and 3 Black Caribbean. There were 70 Caucasian (White British,

Irish or Other) and 30 non-Caucasian patients. 49 patients (36 Caucasian and 13 non-Caucasian) had confirmed radiographic axial SpA. 17 patients (10 Caucasian and 7 non-Caucasian) had confirmed non-radiographic axial SpA.

Based on available data for 57 patients, the median time of symptom onset to GP presentation was 48 months. Based on available data for 49 patients, the median time of symptom onset to diagnosis was 53 months. The mean time of symptom onset to GP presentation was 93 months in Caucasians compared to 66 months in non-Caucasians. The mean time of symptom onset to diagnosis was 91 months in Caucasians compared to 70 months in non-Caucasians. 12 patients presented within 1 year of symptom onset.

Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) data were available for 7 out of 12 patients who presented within 1 year of symptom onset and 25 out of 45 patients who presented after 1 year. Following NSAIDs or biologics, there was a larger decrease in the first measured BASDAI for those who presented within 1 year of symptom onset (Mean BASDAI decrease: 2.77 compared to 2.06).

For those presenting within 1 year of symptom onset, BASDAI data were available for 5 out of 7 Caucasian and 2 out of 5 non-Caucasian patients. The mean BASDAI decrease was 5.65 in non-Caucasian patients compared to 1.62 in Caucasian patients.

For those presenting after 1 year of symptom onset, BASDAI data were available for 15 out of 26 Caucasian and 10 out of 19 non-Caucasian patients. Mean BASDAI decrease was 2.26 in non-Caucasian and 1.93 in Caucasian patients.

BASDAI data were available for 43 out of 70 Caucasian patients and 18 out of 30 non-Caucasian patients, regardless of time of presentation. The mean decrease in first measured BASDAI was smaller in Caucasian patients compared to non-Caucasian patients (Mean BASDAI decrease: 2.49 compared to 2.66).

Conclusion: There is a shorter mean time of symptom onset to GP presentation and diagnosis in non-Caucasian patients compared to Caucasians. There is a higher response to treatment in patients who present within one year of symptom onset. This may support the hypothesis that early diagnosis leads to better outcomes.

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AB0730 RECLASSIFICATION INTO VERY HIGH CARDIOVASCULAR RISK AFTER CAROTID ULTRASOUND IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Axial spondyloarthritis (a-SpA) are associated with an increase in cardiovascular (CV) morbidity and mortality. Subclinical atherosclerosis, in the form of carotid plaques, is more frequent in this patients than in healthy controls. How the presence of carotid plaque affects the reclassification of CV risk in a-SpA has not been study before. Besides, it is not known if this reclassification can be explained by characteristics related to the disease.

Objectives: To analyze whether the reclassification of CV risk after performing carotid ultrasound is more frequent in this patients compared to controls and whether this reclassification can be explained by characteristics related to the disease such as activity, functional damage or metrolgy scores.

Methods: Study of 343 a-SpA patients according to ASAS criteria and 177 controls with no previous history of CV events, diabetes or chronic kidney disease. The clinical characteristics and risk profile were analyzed in patients and controls by SCORE. The presence of plaques and intima-media thickness (cIMT) was determined by carotid ultrasound. The differences in the presence of reclassification between patients and controls and the factors associated with this in patients with a-SpA, were analyzed by multivariate regression analysis.

Results: Patients with a-SpA compared to controls disclosed a higher presence of hypertension (p=0.000), dyslipidemia (p=0.000) and smoking (p=0.000). Consequently, patients also showed a significantly higher SCORE than controls (0.6 IQR [0.1-2.0] vs. 0.1 [0.0-0.4], p=0.000). The presence of carotid plaque (36% vs. 25%, p=0.010) and cIMT (0.641 ± 0.121 vs. 0.602 ± 0.115 mm, p=0.001) were higher in patients compared to controls. Moreover, the possibility of being reclassified into very high-risk category after ultrasound was superior in patients (34% vs 25%, p=0.037). The possibility of being reclassified was associated, both in patients and controls, with an older age, male sex, abdominal circumference, hypertension and dyslipidemia. Contrary, body mass index and