Figure 1. Difference in BMI in the person with unstable height and stable body mass.

Objectives: To evaluate changes in height and BMI over time in patients with axSpA, treated with tumor necrosis factor- α inhibitors (TNF- α).

Methods: The study included 51 patients with axSpA (ASAS criteria 2009). All the patients were treated with TNF- α for one and > years. The patient's height and weight measured before the beginning TNF- α inhibitors and during the treatment. Only patients with stable weight (variability ± 2.0 kg from baseline) were included in the study.

Results: Mean age of axSpA patients at baseline was 40.22 ± 13.51 , 38 (74.5%) were male, disease duration 12.77 ± 6.82 , duration of TNF- α inhibitors treatment 5.64 ± 2.21 years, all the patients had inactive disease. In 19 patients with axSpA diagnostic delay was 8 years.

Patients' height varied between 1.55 – 1.92 m (average height 1.73 ± 0.07 m). Male's mean height was 1.78 ± 0.05 m, women's – 1.63 ± 0.05 m. Height decrease over time in patients with AxSpa was 3.74 ± 1.83 cm (from 1.0 to 15.0 cm). Maximal decrease in height was shown in patients with 10 years after the first symptoms emerged. Mean weight in patients who had height loss was 79.75 ± 12.7 kg. Among patients who had decrease of height and stable body mass the difference between BMI at subsequent measurement and the time of treatment initiation (Δ BMI) was 1.15 kg/m^2 : BMI at baseline = $26.25 \pm 3.34 \text{ kg/m}^2$, over time of observation BMI = $27.39 \pm 3.38 \text{ kg/m}^2$.

Conclusion: Height loss in axSpA is significant even in patients with inactive disease. Height loss affects BMI calculation that could lead to overestimation of cardiovascular risk, obesity and could change all of the BMI-dependent areas. Correction of BMI calculation for the patients with unstable height is needed.

Disclosure of Interests: Elizaveta Vasilenko: None declared, Olga Nikolaeva: None declared, Anna Dadalova: None declared, Ekaterina Gaydukova: None declared, V Mazurov Grant/research support from: JSC BIOCAD, Inna Gaydukova Grant/research support from: JSC BIOCAD, Speakers bureau: payment from Pfizer, Novartis, Abbvie, Biocad, Selgene, MSD, Sanofi not exceed 10 000 euros
DOI: 10.1136/annrheumdis-2019-eular.5994

AB0734B

BONY BRIDGE ON FACET JOINT OR LATERAL SIDE OF LUMBAR VERTEBRA IS MORE FREQUENT AND CORRELATED WITH LUMBAR FLEXION FUNCTION THAN THAT ON ANTERIOR SIDE OF LUMBAR VERTEBRA IN ANKYLOSING SPONDYLITIS; ANALYSIS OF ANKYLOSIS REGISTRY OF AXIAL SPONDYLOARTHRITIS (ANKAS)

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Background: Ankylosing spondylitis (AS) is a form of chronic inflammatory arthritis characterized by sacroiliitis and a marked propensity for sacroiliac joint and spinal fusion. The modified Stoke Ankylosing Spondylitis Spinal Score (mSASSS) has been used when measuring radiographic progression in AS, which only measures bony changes of anterior side in vertebral body (AV). Variation of this score is too small to assess radiographic progression in AS. Some patients have syndesmophytes on lateral side in vertebral body (LV) or ankylosis in facet joints (FJ).

Objectives: We planned this study to know which side of lumbar vertebra ankylosis more frequently develops in and is more correlated with lumbar flexion function.

Methods: We analyzed ANKylosis registry of Axial Spondyloarthritis (ANKAS). In this cohort, the patients with AS are examined by antero-posterior and lateral view of X-ray every 2 years and low dose whole spine computed tomography (CT) every 5 years to determine radiographic progression. We analyzed the location of near total or total bony bridge at each level of lumbar spine by X-ray and CT in 518 patients with AS.

Results: Male was 78% and mean age was 38.8 ± 2.8 . Ankylosis or bony bridge in sacroiliac joint (SIJ), FJ, LV and AV was respectively 55.2%, 22.8%, 21.6% and 13.1%. T12L1 was the most frequent level of ankylosis in FJ (31.7%) and LV (30.3%). For FJ and LV, there was a tendency that upper levels of spine have more ankylosis, but not in AV. The patients who didn't have SIJ ankylosis also have a tendency of not having any bony bridge in lumbar spine (negative predictive value: 92.24%, OR 28.1, 95% CI:16.3-48.4, $p=0.000$). We analyzed the correlation between the flexion score of Bath AS Metrology Index (BASMI) 10 and the site of ankylosis. FJ ankylosis showed the strongest correlation with lumbar flexion range ($R^2=0.456$, $p=0.000$), but bony bridge of LV and AV showed weak correlation with that (respectively, $R^2=0.288$, $R^2=0.155$, $p=0.000$). We analyzed the correlation between ankylosis of FJ and bony bridge of AV or LV respectively. Ankylosis of FJ and bony bridge of LV showed a stronger correlation ($R^2=0.712$, $p=0.000$) than that of AV ($R^2=0.515$, $p=0.000$).

Conclusion: Bony bridge in LV is not only more developed and correlated with ankylosis in FJ, but also more correlated with limitation of anterior lumbar flexion than that in AV. We suggest bony changes of LV should be also included in radiographic score system for more sensitive detection of radiographic progression in AS.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.2020

AB0734C

REMISSION IN AXIAL SPONDYLOARTHRITIS: A DELPHI-METHOD QUESTIONNAIRE AMONG EXPERTS TO EVALUATE THE AVAILABLE ASSESSMENT TOOLS TO MEASURE DISEASE ACTIVITY AND TO DEVELOP A CONSENSUS DEFINITION OF REMISSION

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Background: Several definitions of remission in axial spondyloarthritis (axSpA) have been proposed based on the available disease activity assessment tools, but to date we lack a universally accepted definition of remission for the development of clinical trials or routine clinical practice.

Objectives: To explore the degree of agreement that exists among the experts managing patients with axSpA regarding the assessment tools available to evaluate disease activity in these patients and to develop a consensus definition of clinical remission in axSpA.

Methods: As a consensus method, we followed the modified Delphi methodology. A scientific committee developed 80 statements that were submitted in 2 rounds (in September and October 2018, respectively) to a panel of 152 rheumatologists from GRESSER (GRupo de Estudio de ESpondyloarthritis de la Sociedad Española de Reumatología), the Spanish working group with common interests in spondyloarthritis, addressing controversial issues regarding the current assessment of remission; clinical features, laboratory and imaging tests results, and if they should be