REFERENCES


REFERENCES
Scientific Abstracts

Table: MASEI score:

<table>
<thead>
<tr>
<th>Ultrasound Findings</th>
<th>Case (n=144)</th>
<th>Control (n=24)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of entheses changed</td>
<td>1728</td>
<td>288</td>
<td>307</td>
</tr>
<tr>
<td>Structure (n (%)</td>
<td>472 (27.3)</td>
<td>16 (5.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Thickness (n (%))</td>
<td>503 (29.1)</td>
<td>37 (12.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Bursitis (n (%)</td>
<td>95 (16.5)</td>
<td>05 (7.3)</td>
<td>0.004</td>
</tr>
<tr>
<td>Erosion n (%)</td>
<td>42 (2.8)</td>
<td>02 (0.7)</td>
<td>0.035</td>
</tr>
<tr>
<td>Calcification (n (%))</td>
<td>373 (21.6)</td>
<td>34 (11.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PD (n (%))</td>
<td>124 (7.2)</td>
<td>08 (2.8)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Test: Chi-Square; (PD: power Doppler).

Disclosure of Interests: None declared


AB1162 ARE SONOGRAPHIC FINDINGS CORRELATED WITH DISEASE ACTIVITY SCORE IN RHEUMATOID ARTHRITIS REMITTED PATIENTS?

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Background: Obtaining remission is the ultimate and now attainable goal of treatment in rheumatoid arthritis (RA). However, the definition of remission varies over the last decade. Several composite scores and indices are now validated to assess remitting RA such as the Disease Activity Index 28 joints (DAS28), and more recently, the Simplified Disease Activity Index (SDAI) and the Clinical Disease Index (CDAI). Despite more stringent definition criteria, progressive radiographic damages still occur in RA patients who reached remission. Defining other criteria for remission including ultrasound (US) might help preventing such evolution.

Objectives: The aim of this study was to compare US findings and composite score results in RA patients that achieved a status of remission according to the DAS28.

Methods: Thirty Tunisian patients followed up for RA with DAS28 ≤2.6 for at least three months were enrolled. Among them, we identified patients in remission according to the SDAI (≤3.3) and the CDAI (≤2.8). US (Esaote Mylab 60 machine and a 13-18 MHz linear array transducer) was performed by an experienced rheumatologist blinded to clinical and laboratory data. For each patient, 22 joints were scanned (wrists, metacarpophalangeal, and proximal interphalangeal joints) using a semi-quantitative score.

Results: Over the 26 patients in CDAI remission, ultrasonographic synovitis in B-mode were noted in 81% of patients. The average ultrasound score per patient was 4.58. In PD mode, US abnormalities were noted in 58% of patients. The average PD score per patient was 2.6. Neither correlation between CDAI and B-mode US score (r = 0.104; p = 0.319) nor between CDAI and PD US score (r = 0.251; p = 0.217) was noted.

CAN A MUSCULOSKELETAL ULTRASOUND REPORT CHANGE A RHEUMATOLOGIST’S OPINION?

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Background: The era of musculoskeletal ultrasound (MSUS) is becoming enormous, but the extent to which MSUS has influenced management plans for patients with different musculoskeletal symptoms remains questionable.

Objectives: To assess the changes in the provisional diagnosis and treatment decisions made by rheumatologists after receiving MSUS reports for their patients.

Methods: This study has been carried out at Rheumatology & Rehabilitation outpatient clinic in Zagazig University Hospitals in Egypt. This is an observational study on 101 patients with musculoskeletal complaints who have been referred by rheumatologists for a MSUS scan at Zagazig University MSUS Unit in the same department. The patients' mean age was 41.5 ± 15.67, including 70 females (69.3%) and 31 males (30.7%). Patients included 29 patients with hand/wrist complaints (28.7%), 2 patients with elbow pain (2%), 36 patients with shoulder pain (35.6%), 7 patients with ankle/foot pain (6.9%), 10 patients with knee pain (9.9%), and 17 patients with polyarticular pain (16.8%). The rheumatologists were asked to set a provisional diagnosis and treatment plan before the MSUS scan and then consider their own plan for any adjustments afterwards.

Results: Regarding all 101 patients, the diagnosis & treatment decisions were changed in 37% and 65% respectively after the MSUS scan as shown in figure (1). Fifty percent of the changes in treatment were classified as minor in the form of adding/changing the type of NSAIDs, adding/changing the dose of steroids, changing the dose of DMARDs and adding/modifying physiotherapy while the other 50% were major in the form of initiating/adding DMARDs, interventional treatment referral to surgery. Ten patients out of 29 with hand/wrist complaints encountered change in diagnosis (34.5%), 1 patient out of 2 with elbow pain (50%) and 11 patients out of 36 with shoulder pain (30.6%). In patients with knee pain and ankle/foot pain, changes occurred with 4 patients for each representing 40% and 42.9% respectively. Regarding patients with polyarticular complaints 8 patients representing 47.1% were categorized to different disease entities. Treatment decisions were much more frequently changed as more pathological details were clarified by MSUS. Treatment decision changes occurred in 83.3% of patients with shoulder pain 70% of which were minor mainly due to better evaluation of rotator cuff syndromes grading tears and detecting bursitis. While for knee pain 50% of treatment decisions were changed of which 60% were major as in knee osteoarthritis detection of significant synovitis & Baker’s cysts lead to interventional treatment. Regarding patients with hand/wrist polyarticular complaints, 44.8% and 68.8% of treatment decisions were changed respectively of which 75% and 90.8% were major owing mainly to changes in diagnosis detecting subclinical activity. Finally regarding ankle/foot pain, treatment changes happened in 71.4% of which 80% were minor.

Disclosure of Interests: None declared

EDUCATION ON PEDIATRIC MUSCULOSKELETAL ULTRASOUND: A SYSTEMATIC LITERATURE AND EVENTS REVIEW

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Background: Recently some Pediatric musculoskeletal ultrasound (PedMSUS) courses have been held on national and international ground. Nonetheless, content, conduct and format of PedMSUS courses have never been investigated and shared.

Objectives: To perform a systematic literature and events review on PedMSUS educational initiatives.

Methods: Educational material/events on PedMSUS were extensively searched on websites/networks (PubMed, Cochrane, Embase, ERIC, Medline, CINAHL complete, Google, Yahoo, Ask, Baidu, Bing, Lycos, Duckduckgo). The keywords were: “musculoskeletal”, “ultrasound”, “sonography”, “course”, “education”, “training”, “children”, “paediatrics”, “pediatrics”. Only courses/events, articles and books in English were considered. Descriptive analysis was performed on the documentation retrieved.

Results: No articles neither books on educational recommendations for PedMSUS courses were found. A total of 13 PedMSUS courses were identified. Two online courses and three residential ones were not consistent with the purpose and were excluded. Eight courses were finally included for the analysis (Figure 1). Seven were endorsed by EULAR and followed the recommendations for the content and conduct of EULAR MSUS courses. No requirements/skills should be fulfilled for registration; only one level of competency was proposed. The courses were residential of 2-3 days and included theoretical and practical lessons. Lectures were on MSUS examination techniques, physiological musculoskeletal (MSK) anatomy and basic pathologic in pediatric rheumatology. Hands-on scanning of healthy models/patients with pediatric rheumatic diseases was generally organized in groups supervised by tutors, and included optimization of the machine settings, identification of pediatric MSK sonoanatomy, correct acquisition of images, and identification of basic pathological findings in children. A competency assessment was performed at the end of only three courses.