respectively) were the most frequent extra-articular manifestations of SLE. Few patients experienced main systemic signs such as renal (67 patients, 38%) and neurological (9 patients, 5%) disorders, vasculitis (6 patients, 3%), and serositis (43 patients, 24%).

The studies included in the present analysis are displayed in Table 1.

Conclusion: We observed a strong heterogeneity in the elements taken into account to establish the presence of rhupus, reflecting the lack of consensus and validated criteria to define the disease. Rhupus can represent an aggressive and disabling condition, and a harmonization in the classification criteria might represent the first step to improve the management of these patients.

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AB1178

PLANTOGRAPHIC ASSESSMENT OF FOOT DEFORMITIES IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: In almost one third of the patients with rheumatoid arthritis (RA) the disease begins with involvement of the small joints of the feet with high risk for developing significant foot deformities with disease progression. Irreversible structural changes occur as a result of synovitis combined with mechanical stress. The pain and the impaired static cause functional disability in these patients and the orthotic correction is often limited and with no evidence for effectiveness.

Objectives: To assess the foot structure and determine the incidence of foot deformities in patients with RA with different disease duration ranging from 3 months to more than 10 years.

Methods: Forty two RA patients (32 women and 10 men) underwent assessment of the foot structure under an axial load and while walking on a pressure measuring plate as well as a 3D scan of the feet.

Results: The most common foot deformities found in the study group included hallux valgus deformity in 73,81%, flattening of the medial longitudinal arch in 64,29% and valgus deformity of the calcaneus in 35,71% of the patients.

Conclusion: The introduction of the plantography in the clinical practice offers the opportunity for early diagnosis of foot deformities in patients with RA and indicates the necessity of correction through orthotics or surgery.

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AB1179

TYPES OF JOINT LESIONS IN REACTIVE ARTHROPATHY

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Background: Differential diagnosis of ReA has certain difficulties, especially at an early stage in the absence of confirmation of trigger infection. Radiographic signs of joint damage when the response are not specific and appear not earlier than 3-6 months from the onset of the disease; enthesitis this method is not visualized, making it difficult to timely diagnosis of ReA [1]. To determine the tactics of patient management and selection of adequate therapy is no less important to determine the duration and characteristics of the course of ReA.

Objectives: To study the ultrasonic features of joint lesions in reactive arthropathy depending on the course of the disease.

Methods: We examined 66 patients with Rea who met the preliminary international criteria were examined (4th International Workshop on Reactive Arthritis, Berlin 1999). Women were 26 (39%), men - 40 (61%),

median age - 34 years (31-42), median duration of ReA- 1 year (0.3-3.25). Among the patients there were 40 (61%) people with acute ReA and 26 (39%) people with chronic ReA. All patients had confirmed chlamydial infection (PCR and IFA). Patients underwent a comprehensive clinical and laboratory examination, MRI and ultrasound of the knee joints. Statistical processing of the information package.

Results: The MRI of the affected joints clearly visualized inflamed entheses and the presence of local osteitis with an erosive defect of the closing plate of the bone (Fig.1).

Figure 1

In patients with acute ReA were visualized: thickening of entheses more than 3 mm (98%), hypo-, anechogenic areas in the projection of the tendon-ligamentous apparatus and places of its fixation (74%), the formation of a bone defect under them with a contour of reduced echogenicity (erosion of acute inflammation - 66,8%) and uneven edges, pronounced effusion (75%), lack of strengthening of local blood flow in the projection of synovia and joint structures (Fig.2).

Figure 2

In patients with chronic ReA, the following were visualized: thickening of entheses to 3 mm (65%), hyperechogenic inclusions in the projection of the tendon-ligamentous apparatus and its fixation sites (53%), the formation of a bone defect under them with a contour of increased echogenicity (erosion of chronic inflammation - 46,9%) and uneven edges, slight effusion (28%), the absence of strengthening of local blood flow in the projection of synovia and joint structures (Fig.3).

Figure 3

All patients with ReA were found to have a positive "pain test" in palpation of the affected entheses under the control of ultrasound entesopathy.

Conclusion: Based on the results we have made the following conclusions:

- 1. Ultrasound of joints allows to identify and assess the nature of joint lesions depending on the duration of the ReA.
- 2. Ultrasound criteria of acute ReA: enthesitis, erosion acute inflammation under affected entheses, enthesopathy expressed by secondary synovitis.
- 3. Ultrasound criteria for the chronic course of ReA: enthesitis, erosion of chronic inflammation under the affected entheses, enthesopathy, minor secondary synovitis, calcinates.

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AB1180 ULTRASOUND SEMIOTICS OF DEFEATS OF THE JOINTS IN REACTIVE ARTHRITIS AND OSTEOARTHRITIS

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Background: The most common cause of knee joint damage in people of working age is osteoarthritis. However, in recent years, cases of reactive arthropathy, which often takes a chronic course, have become more frequent [1]. Given the current possible ultrasonic equipment, relevant is the study to study the ultrasonic features of defeat of joints with ReA and OA.

Objectives: To study the ultrasonic features of joint lesions at osteoarthritis and reactive arthritis.

Methods: We studied 55 patients with ReA and 22 patients with OA. Among patients with ReA were 25 women and 20 men, median age was 31 years (18 to 47), the median duration of the current Imple - of 2.86 (0,07-29,0) months. Among patients with OA were examined in 15 women and 7 men, median age was 56.5 years (43-61), the median duration of flow OA - 139 months (12-360 months). All patients with ReA at the time of the study or in history had confirmed genital chlamydial infection. All patients were multiphasic dynamic study of the knee by the ultrasonic device expert class using a sensor with a frequency of 12 MHz.

Results: As a result of the ultrasound examination of the 110 joints with ReA, we have identified: pronounced synovitis in 69 (62.7%) joints, but the absence of pathological vascularization in the projection of the synovial; narrowing of the joint space 73 (66.4%) joint; heterogeneous structure of the ligament in 82 (75%) joints, tenosynovitis in 20 (18%) joints, thickening entheses in 89 (80.9%) joints, hypoechoic entheses in 72 (65.5%) joints, hyperechoic inclusions in projection entheses in 39 (36%) joints; local osteolysis of cortical layer of bone in the fixation entheses with the formation of erosive lesions in 77 (70%) joints, osteitis 26 (23.6%) joints; swelling parenthetically in 81 (74%) joint effusion parenthetically 49 (44.5%) joints (Fig. 1 a,b,c).

a. b. c.

Fig.1(a,b,c) Ultrasound examination of knee joints in a patient with ReA

As a result of the ultrasound examination of the 44 joints with osteoarthritis, we have identified: a decrease in the thickness of the cartilage and narrowing of the joint space of degree 1 in 14 (31.8%) joints, reducing the thickness of the cartilage and narrowing of the joint space of 2 degrees in 22 (50%) of the joints, reducing the thickness of the cartilage and narrowing of the joint space grade 3 in 20 (45.6%) joints; subchondral osteosclerosis and cysts rebuilding bone was detected in 42 (95.5%) joints, the heterogeneity of the cords in 15 (of 34.10%) joints, thickened ligaments in 1 (2.30%) joint; single marginal osteophytes in 26 (59.1%) joint; multiple osteophytes in 20 (45.50%) joints; 29 (65.9%) joints detected a moderate effusion (Fig.2 a,b,c).

b. b. c.

Fig.2 (a,b,c) Ultrasound examination of knee joints in a patient with OA

Conclusion: Ultrasound criteria of joint damage in ReA are: no hypervascularization synovial; pronounced synovitis; narrowing of the joint space; thickening entheses with hypo-anechoic areas; local osteitis with osteolysis of the cortical layer of bone in the fixation entheses and the formation of erosive lesions; parenthetically swelling.

Ultrasound criteria of lesions of the joints in OA are: narrowing of the joint space; thinning hrase; hyperechoic zones of subchondral osteosclerosis; cysts rebuilding of the subchondral bone; hyperechoic marginal osteophytes.

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AB1181 ULTRASOUND PATHOLOGICAL PATTERNS AT CARPAL TUNNEL LEVEL IN RHEUMATOID ARTHRITIS AND IDIOPATHIC CARPAL TUNNEL SYNDROME

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Background: High-frequency ultrasound (US) has proven to be a useful imaging tool for the evaluation of carpal tunnel pathology. US impact in the assessment of idiopathic carpal tunnel syndrome (CTS) has been widely investigated, but only few studies have been carried out with the aim of revealing the pathologic conditions responsible for CTS in rheumatoid arthritis (RA) patients¹.

Objectives: The aim of this study is to evaluate US findings at carpal tunnel level in a cohort of patients with RA, focusing on those with a clinical diagnosis of CTS, and to compare these findings with those observed in a cohort of patients with idiopathic CTS (without RA).

Methods: Fifty-six patients with RA fulfilling the ACR/EULAR 2010 classification criteria were consecutively enrolled. CTS was diagnosed according to the American Academy of Neurology practice parameter for CTS. We also enrolled 19 patients with idiopathic CTS and evaluated 24 symptomatic wrists, excluding those already surgically decompressed. The US assessment was performed using a MyLab ClassC (Esaote SpA) US system, working with a 6-18 MHz linear probe. The power Doppler (PD) frequency was set at 9.1 MHz. The following grey scale (GS) US pathologic findings were assessed at the carpal tunnel level: cross-sectional area (CSA) of the median nerve at the carpal tunnel inlet (at the level of the pisiform and scaphoid bones), presence of finger flexor tenosynovitis and palmar radio-carpal synovitis (both in GS and PD), and marked bone profile irregularities. The median nerve was considered enlarged if its CSA was more than 12 mm². We evaluated the presence of intra-neural PD signals at the carpal inlet and scored its entity (0=no PD signal, 1=one single vessel within median nerve, 2=two or three single or two confluent vessels and 3=more than three single or more than two confluent vessels).

Results: CTS was diagnosed in 21 out of 112 wrists (18.75%) and in 14 out of 56 RA patients (25%).

Enlarged median nerve was found in 4 out of 21 wrists with RA and CTS (19%), in 6 out of 84 wrists of patients without CTS (7.1%) and in 22 out of 24 wrists of patients with idiopathic CTS (91.7%). Flexor tenosynovitis was found in 6 out of 21 wrists with RA and CTS (28.6%), in 8 out of 84 wrists of patients without CTS (8.2%) and in 4 out of 24 wrists with idiopathic CTS (16.7%). Palmar radio-carpal synovitis was found in 4 out of 21 wrists with CTS (19%), in 10 out of 84 wrists of patients without CTS (11.9%) and in 1 out of 24 wrists with idiopathic CTS (4.2%). Marked bone profile irregularities were detected in 3 out of 21 wrists with CTS (14.3%), in 22 out of 84 wrists without CTS (26.2%) and in none of the patients without RA. In RA patients, positive intra-neural PD signal was found in 9 out of 21 wrists with CTS (42.8%) and