The implementation of this profile of auto-antibodies in patients without ILD and those without clinical and/or analytical characteristics associated with MII, did not provide any.

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AB1316

AGREEMENT BETWEEN SUBJECTIVE AND OBJECTIVE DEFINITIONS OF INACTIVE DISEASE IN CHILDREN WITH JUVENILE IDIOPATHIC ARTHRITIS

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Background: The choice of an appropriate definition of inactive disease (ID) is important because ID has been identified as the ideal therapeutic goal in the treat-to-target strategy in juvenile idiopathic arthritis (JIA).¹ Several criteria for ID in JIA have been proposed, including Wallace 2004 and 2011 criteria and JADAS10 and clinical JADAS10 (cJADAS10) criteria. However, a recent study² has shown that these criteria do not always identify the same group of patients. In addition, it is unknown whether and to what extent the formal definitions of ID agree with the subjective perception of disease remission by the physician and the parent.³

Objectives: To investigate the concordance between current criteria for ID and subjective judgment of disease remission by physicians and parents in children with JIA.

Methods: We evaluated the clinical data of the last visits made in 669 children with JIA from March 2007 to December 2010 to identify all visits in which the caring physician and a parent judged subjectively and independently the child's disease state as remission or non-remission and the parent declared whether he/she was satisfied or non-satisfied with current illness state (i.e. Parent Acceptable Symptom State, PASS).⁴ All visits judged subjectively by the physician and the parent as remission or judged in PASS by the parent were examined to identify those which met the Wallace 2004 and 2011 criteria and the JADAS10 and cJADAS10 criteria for ID. Visits which met both subjective and objective definitions were defined as concordant.

Results: Of the 246 visits in which the physician judged subjectively the disease state as remission, 34.6% and 27.6% met the 2004 and 2011 Wallace criteria, respectively, and 38.6% and 54.5% met the JADAS10 and cJADAS10 criteria for ID, respectively. (Figure 1) Of the 338 visits in which the parent judged subjectively the disease state as remission, 19.8% and 18% met the 2004 and 2011 Wallace criteria, respectively, and 34.9% and 48.8% met the JADAS10 and cJADAS10 criteria for ID, respectively. (Figure 2) In 76.4% of visits judged as remission by the physician, the parent provided the same evaluation. In 55.6% of visits judged as remission by the parent, the physician provided the same evaluation. (Figure 1-2) Of 467 visits judged in PASS by the parent, 17.6% and 14.8% met the 2004 and 2011 Wallace criteria, respectively, and 26.6% and 37.5% met the JADAS10 and cJADAS10 criteria for ID, respectively.

Conclusion: The JADAS10 and cJADAS10 criteria for ID were more concordant with physician's and parent's subjective judgment of remission and with parent's satisfaction with current illness state than Wallace criteria. The cJADAS10, which lacks the acute phase reactant, revealed the best concordance with both physician's and parent's subjective assessments. Physician-parent agreement was greater for remission judged by the physician than for remission judged by the parent.

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Figure 1. Physician-centered inactive disease state evaluation.

Figure 2. Parent-centered inactive disease state evaluation.

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AB1317

WHAT IS A TOTAL KNEE OR TOTAL HIP ARTHROPLASTY FAILURE? A PATIENT PERSPECTIVE USING NOMINAL GROUPS

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Background: Total joint replacements (TJR) are commonly performed elective surgeries for people with end-stage arthritis. However, there is relative lack of qualitative research to define the patient perspective of what constitutes a failure of TJR

Objectives: To discover when a TJR is considered a failure from the patients' perspective using nominal group technique (NGT).

Methods: Patients who had undergone elective total hip (THR) and/or knee replacements (TKR) met in nominal groups to answer the question "When would you consider a knee or hip replacement to be a failure?". Patients completed questionnaires including demographics, pain, function, and satisfaction, independently listed their ideas and then ranked them with the group after clarification.

Results: Six groups with 35 patients were held, all of whom had undergone THR and/or TKR between 2016 and 2018. Of these, 42% were male, 17% black (Table 1). Overall pain and function scores were high; Hip Disability and Osteoarthritis Outcome Score (HOOS) JR 95.3 (SD+/-11) and Knee Injury and Osteoarthritis Outcome Score (KOOS) JR 83.7 (SD+/-12.8) (range 0-100, higher score=less pain/functional limitation), and 86.1% were very/somewhat satisfied with their quality of life. The concerns ranked highest by the patients equating a TJR failure were A) refractory index joint pain (67 votes); B) unable to resume normal activities or go back to work (38 votes); C) minimal or no improvement in quality of life (24 votes); D) post-operative adverse events (40 votes); E) early revision surgery (32 votes); F) death (7 votes); G) expectation-outcome mismatch (1 vote); continuing secondary depression (1 vote) (Table 2).

Conclusion: Poor results for pain, function, quality of life, or adverse events are the outcomes ranked highest by patients, defining TJR failure from the patients' perspective.

Table 1. Baseline Characteristics	TKR N=19	THR N=13	Both TKR and THR N=3	Total N=35
Age (mean, SD)	75.7 ±8.2	65.3 ±8.0	66.3±5.4	71.1±9.4
Men, n(%)	6 (31.6)	8 (61.5)	1 (33.3)	15 (42.9)
Black, n(%)	3 (15.8)	3 (23.1)	-	6 (17.1)
Asian, n(%)	-	-	1 (33.3)	1 (2.9)
Multi-race, n(%)	1 (5.3)	1 (7.7)	-	2 (5.7)
Education				
High school, n(%)	-	1 (7.7)	-	1 (2.9)
Some college, n(%)	1 (5.3)	3 (23.1)	-	4 (11.4)
College or above, n(%)	18 (94.7)	9 (69.2)	3 (100)	30 (85.7)
Employment				
Employed, n(%)	3 (15.8)	9 (69.2)	3 (100)	15 (42.9)
Self-employed, n(%)	4 (21.1)	3 (23.1)	-	7 (20.0)
Out of work, not looking for work, n (%)	1 (5.3)	-	-	1 (2.9)
Retired, n(%)	11 (57.9)	1 (7.7)	-	12 (34.3)
Reason for surgery				
Osteoarthritis, n(%)	13 (68.4)	11 (84.6)	3 (100)	27 (77.1)
Rheumatoid arthritis, n(%)	2 (10.5)	1 (7.7)	-	3 (8.6)
Other arthritis, n(%)	3 (15.8)	1 (7.7)	-	4 (11.4)
Avascular necrosis of the bone, n (%)	1 (5.3)	-	-	1 (2.9)

Abstract AB1317 Table 2. Theme: When would you consider a hip or knee replacement a failure? Score

NG 1-6, 35 people, 14 Male, 21 Female; 8 African-American, 25 White, 2 Asian, 210 votes*

A. Pain: Still in pain/remains unchanged/persists	67
• "Primary factor for getting surgery. Pain impacts every facet of life"	
B. Activities: Cannot regain normal function or activities/physical disability persisted	38
• "Can't reach a goal – goal is to reach the top of the stairs or room"	
C. Quality of life	24
• "Can't go back to work and can't walk. Purpose of surgery to get back life. Going to theater, cooking. Social, mental, physical, emotional."	
D. Adverse Events: Infection, implant rejection, bone damage, complications	40
• "Infection sets you back, psychological event, when does it get cured, do I have to go back for surgery. Start questioning everything."	
E. Revision: Having another surgery for the same problem	32
• "Did not want to go through it again"	
F. Death: infection leading to death, implant causing death, death during surgery	7
• "Friend died of infection, that's why I came here"	
G. Other	2
• "When outcomes don't meet expectations"	

*combined votes; NG= nominal group

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AB1318

VALUE OF NEW BIOMARKERS IN THE DIFFERENTIAL DIAGNOSIS OF SARCOIDOSIS AND TUBERCULOSIS

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Background: Due to multisystem involvement with almost similar presentation, tuberculosis (TB) and sarcoidosis poses a diagnostic challenge. As both of them show granulomatous inflammation in tissue, even histopathological examination is not helpful to differentiate the two. As a result of this difficulty, new biomarkers for differentiating the two are being investigated. Previous studies (1,2) done in other regional population attempted to show the efficacy and role of Neutrophil by lymphocyte ratio (NLR) and platelet/lymphocyte ratio (PLR) to differentiate sarcoidosis from TB, with inconsistent results. We attempt to see if these biomarkers can be used in our population to differentiate the two.

Objectives: The aim of our study was to investigate the value of neutrophil/lymphocyte ratio (NLR), and platelet/lymphocyte ratio (PLR) to differentiate TB from sarcoidosis. In addition, we also studied Neutrophil/lymphocyte/albumin/globulin ratio (NLR by A:G ratio) as a novel marker for differentiating the two.

Methods: Patients recruited for the study were selected retrospectively from hospital records during the period of September 2017 to December 2018:

1. 50 consecutive pulmonary TB patients diagnosed based on sputum acid-fast bacilli (AFB) positivity and/or culture-positivity
2. 39 consecutive patients diagnosed with sarcoidosis by an experienced Rheumatologist on clinical and histological grounds.
3. 50 consecutive healthy subjects who presented to general comprehensive check up on Monday of every week. Subjects who were having any autoimmune disease or infections were excluded.

We collected the information including clinical and biochemical parameters at the time of presentation, from the hospital records. NLR, NLR by A:G ratio and PLR were calculated. To test the statistical significance of continuous variables between sarcoid and tb student's t test/Mann Whitney U test was used. To find the cut off value of study variables, ROC curve was used. Diagnostic measures like sensitivity, specificity, predictive values and accuracy was computed.

Results: Though age was comparable, sex ratio varied between groups with more females in sarcoidosis group. Leukocyte count and neutrophil percentage, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), NLR, NLR by A:G and PLR were significantly higher in the TB group compared with sarcoidosis (for all parameters P < 0.001).

Table showing ROC analysis results and accuracy rates of NLR, NLR by A:G ratio and PLR in detection of tuberculosis among sarcoidosis and tuberculosis groups

Parameter	Cut - off	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)	AUC	Accuracy (%)	P value
NLR	3.58	92	73	82	88	0.86	84	<0.001
NLR by A:G ratio	4.48	82	83	87	77	0.88	83	<0.001
PLR	220	64	62	68	57	0.70	63	<0.001

Conclusion: TB vs sarcoidosis is a challenging diagnostic dilemma. Our retrospective study shows the role of NLR, NLR by A:G ratio and PLR in differentiating TB from sarcoidosis. These biomarkers can help to guide our clinical judgement in differentiating these two causes of granulomatous inflammation.

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