Abstract THU0375 – Table 1

	Peripheral center (n = 61)	Academic center (n = 230)	p-value
Age at diagnosis (years)	33,6 (9,23)	31,3 (9,01)	0,08
Male gender	20 (32,8)	118 (51,3)	0,01
HLA B27 positivity	35 (57,4)	169 (73,5)	0,01
Symptom duration at diagnosis (years)	4,8 (5,45)	4,2 (5,60)	0,51
ASAS classification criteria imaging arm	46 (75,4)	204 (88,7)	0,21
ASAS classification criteria clinical arm	35 (57,4)	169 (73,5)	0,01
ASAS classification criteria both arms	23 (37,7)	145 (63,0)	0,01
Arthritis	11 (18,0)	39 (17,0)	0,99
Dactylitis	1 (1,6)	7 (3,1)	0,88
Enthesitis	11 (18,0)	28 (12,2)	0,33
Psoriasis	7 (11,5)	20 (8,7)	0,68
Inflammatory bowel disease	3 (4,9)	14 (6,1)	0,87
Acute anterior uveitis	6 (9,8)	32 (13,9)	0,53
BMI (kg/m ²)	23,8 (3,86)	24,4 (4,02)	0,26
BASMI	1,1 (1,13)	1,3 (1,17)	0,33
MASES + fascia plantaris (/15)	1,4 (2,50)	0,9 (1,54)	0,69
BASDAI (/100)	46 (19,3)	43 (20,2)	0,31
BASFI (/100)	30 (22,5)	28 (21,8)	0,77
ASDAS – CRP	2,43 (0,89)	2,47 (0,93)	0,80

Continuous variables: mean (SD); other: counts(%).

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THU0376 THE VALUE OF SACROILIAC JOINT RADIOGRAPHS IN THE EARLY SPONDYLOARTHRITIS ESPERANZA COHORT

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Background: X-Ray sacroiliitis is the cornerstone in the diagnosis of the ankylosing spondylitis (AS). It is clear that the presence of sacroiliitis is a specific lesion in long standing AS, but little evidence exists on the reliability of this image technique in early axial spondyloarthritis (axSpA), which associates with reduced structural damage. This is relevant because some rheumatologists and pharmacological authorities feel more confident with the diagnosis of AS rather than with non radiographic axial spondyloarthritis (nr-axSpA) forms. On the other hand, according to various research studies, clinicians are subject to potential bias when interpreting radiographs, influenced by their pretest clinical judgment.

Objectives: The aim of this study is to determine the value of X-Ray sacroiliitis in the early diagnosis of axSpA.

Methods: This study included 290 radiographs of the SI joints from patients of the Esperanza early spondyloarthritis cohort. Nine readers, blinded for the diagnosis, participated in the reliability exercise, all of them experienced rheumatologists and members of the Spanish spondyloarthritis working group (GRESSER). Patients with axSpA were classified as having AS if the radiographic criteria of the modified NY criteria (presence of radiographic changes in the SIJ of at least grade II bilaterally or at least grade III unilaterally) were fulfilled. The gold standard was the categorical opinion of at least five of the expert readers. For the statistical analysis, the Chi-square and Kappa tests were performed.

Results: The radiographic diagnosis, sensitivity, specificity, likelihood ratio, grade of agreement and mean K values compared to gold standard are showed in table 1. The concordance Kappa test was highly variable among the readers, ranging from fair to excellent. The agreement with the gold standard varied from 68 to 94% and the sensitivity and

specificity, from 50-100% and 64-96%, respectively. Additionally, the number of AS was 61, with an inter-reader variability rate of 31 to 138. Larger discrepancies were observed when assessing sacroiliitis grade 2.

Abstract THU0376 – Table 1.

	Gold standard	Reader 1	Reader 2	Reader 3	Reader 4	Reader 5	Reader 6	Reader 7	Reader 8	Reader 9
Kappa		716	345	468	606	599	459	612	513	809
Agreement		90.97	68.06	85.52	84.48	85.12	73.79	87.59	78.47	94.14
SIJ mNY+	61	54	138	31	92	80	137	55	115	48
SIJ mNY TP	61	44	53	25	54	49	61	40	57	46
SIJ mNY FP	229	10	85	6	38	31	76	15	58	2
Sensitivity		73.33%	88.33	59.02	88.52	80.33	100	65.57	93.44	75.41
Specificity		95.61%	62.72	97.38	83.41	86.40	66.81	93.45	74.45	91.13
LR +		16.70	2.369	22.53	5.336	5.907	3.013	10.01	3.657	8.502

SIJ = (SI) joint; mNY+ = number of patients that meet diagnosis of ankylosing spondylitis; TP = true positives; FP = false positives; LR+ = Likelihood ratio +

Conclusion: The diagnosis of AS in early axSpA is characterized by a marked variability. At least in doubtful cases, a second central evaluation performed by highly qualified experts should be advisable.

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THU0377 THE CARDIOVASCULAR ASSOCIATIONS WITH ENTHESITIS AND DACTYLITIS IN PATIENTS WITH SPONDYLOARTHRITIS: RESULTS FROM THE ASAS-COMOSPA STUDY

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Background: Enthesitis and dactylitis are considered characteristic inflammatory musculoskeletal manifestations of spondyloarthritis (SpA). These manifestations are usually assessed in the context of their assumed underlying specific condition rather than as distinct entities. Data from the ASAS-COMOSPA cohort have recently been shown that duration of SpA disease is associated with higher odds of hypertension particularly in axial SpA (1).

Objectives: To evaluate the possible associations of dactylitis and enthesitis phenotypes with cardiovascular comorbidities in a heterogeneous cohort of patients with SpA.

Methods: ASAS-COMOSPA is a global cross-sectional study assessing comorbidities in 3984 patients with SpA. History of enthesitis or dactylitis was based on self-report with confirmation using the medical records. Associations between dactylitis or enthesitis with hypertension, dyslipidaemia, diabetes, ischemic heart diseases (IHD) and stroke were analysed by separate logistic regression models unadjusted, adjusted for age and sex (models 1), and adjusted for age, sex and BMI (model 2).

Results: The data of 3905 participants were available for analysis. There were 1480 (37.9%) with history of enthesitis and 611 (15.6%) with dactylitis, while 1814 (46.5%) had neither.

Presence of dactylitis was associated with hypertension in the univariable analysis [OR=1.68; 95%CI: 1.39–2.03]. The association remained significant when adjusted for age and sex, but not following further adjustment for BMI (Table). Similarly, enthesitis was associated with hypertension in the univariable analysis [OR=1.36; 95%CI: 1.17–1.59], which remained after adjusted for age and sex, as well as after further adjustment for BMI (Table). Similar associations were seen for dyslipidaemia and dactylitis [OR=1.60; 95%CI: 1.29–1.98] or enthesitis [OR=1.50; 95%CI: 1.26–1.77], with the association with dactylitis lost after further adjustment for BMI while the association with enthesitis remained significant (Table).

While there were significant associations between dactylitis and diabetes [OR: 1.50 (95% CI: 1.07–2.11)], and between enthesitis and diabetes [OR=1.35; 95%CI: 1.02–1.78] in unadjusted models, no associations were