All analysed outcome parameters (e.g. ASDAS, ASAS-HI, BASDAI, BASFI, patient global, physician global, pain, sleep) were significantly worse in the group of patients with moderate to severe depressive symptoms versus the other patients (table 2). This includes physician-reported, patient-reported and composite scores.

WHO-5 was highly correlated with all outcome parameters regardless of gender. Figure 1 shows the correlation of BASDAI and WHO-5 stratified for gender.

Figure 1.

Conclusion: Almost one third (30%) of axSpA patients in this analysis reported scores indicative of depressive symptoms and depression. The strong correlation of WHO-5 scores with patient and physician reported outcomes may be relevant for the management of patients with axSpA.

References:

[1] Redeker I, et al. Ann Rheum Dis 2018;0:1–8. doi:10.1136

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SAT0392

DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS IN DAILY CLINICAL PRACTICE – A SURVEY AMONG DUTCH RHEUMATOLOGISTS

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Background: Since publication of the ASAS classification criteria for axial spondyloarthritis (axSpA) in 2009¹ and the development of ASAS-endorsed recommendation for early referral of patients with a suspicion of axSpA,² awareness for non-radiographic (nr-) axSpA besides Ankylosing Spondylitis (AS) has increased. Still there is limited information of how nr-AxSpA is addressed in daily clinical practice.

Objectives: To get insight into the diagnostic phase of axSpA in daily rheumatologic practice in the Netherlands, and to explore if nr-axSpA is addressed differently from AS.

Methods: We set up a 21 multiple choice question survey for rheumatologists in the Netherlands with 5 general questions about their practice and 16 questions addressing the diagnostic phase of axSpA. The questionnaire was taken by representatives of the medical department of Novartis NL during structured face-to-face interviews. Rheumatologists in the Netherlands were invited to participate, aiming to get a sample of rheumatologists varying in geographical location and hospital type, as well as a mix of SpA-experts and non-SpA-experts. Rheumatologists gave approval for anonymous use of the data, which were entered in a database and subsequently analyzed using descriptive statistics.

Results: From October 15th 2019 until January 16th 2020, 36 Dutch rheumatologists participated in the face-to-face survey; 6 from university hospitals, 27 from general hospitals and 3 from private care centers. Most of axSpA patients (61%) were referred by the general practitioner and mean time between referral and first visit was 2-6 weeks. More than 50% of rheumatologists reported a mean symptom duration of >1 year and in 30% even >2 years before first visit. For diagnosing axSpA rheumatologists performed in almost all cases X-pelvis (mean 100% (SD 0%) for both AS and nr-axSpA), CRP/ESR (91% (26%) for AS; 94% (22%) for nr-axSpA) and HLA-B27 (74% (40%) for AS; 86% (26%) for nr-axSpA). MRI of the SI joints was performed in 31% and 82% of patients, respectively, and about 60% of the rheumatologists used of classification criteria for diagnosing axSpA. In addition, rheumatologists marked the level of importance of several (SpA) clinical features for making the diagnosis AS or nr-axSpA (Figure 1). Most rheumatologists graded inflammatory back pain, arthritis/enthesitis/dactylitis and uveitis as very important for contributing to the diagnosis. Functional impairment of the spine and male sex were mostly graded neutral or not important for making a diagnosis of axSpA. All features were graded of similar importance for the diagnosis AS and nr-axSpA, except for backpain starting before the age of 45, which was considered more important for diagnosing AS.

Conclusion: This survey among Dutch rheumatologists showed that in 30% of patients referred with possible suspicion of axSpA, symptom duration still was >2 years. Almost 60% of rheumatologists make use of the ASAS classification criteria for diagnosing nr-axSpA. Therefore, for early referral awareness of axSpA in first line should enhance. Furthermore, rheumatologists should become aware that classification criteria are not similar to diagnostic criteria and cannot be used as a tick box for diagnosis.

References:

[1] Rudwaleit M et al, Ann Rheum Dis 2009;68:777-83, 2. Poddubnyy D et al, Ann Rheum Dis 2015;74:1483–7

Figure 1. Level of importance of clinical features for diagnosing axSpA
Values given as % of responders (total of 100% per feature)

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SAT0393

DISCREPANCY IN THE CARDIOVASCULAR RISK SEVERITY CALCULATED USING DIFFERENT RATING SCALES IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Cardiovascular risk (CVR) in patients (pts) with axial spondyloarthritis (axSpA) exceed the populational level. However, it remains unclear, which of the cardiovascular risk assessment systems is the most accurate in cases of chronic inflammation..

Objectives: of the current study were to assess the CVR in pts with axSpA and to compare different cardiovascular risk scales in these pts.

Methods: The study included 118 patients at the age of 25-65 years with diagnosis of axSpA fulfilling ASAS criteria (2009) from St. Petersburg' axSpA register. Three indices of cardiovascular risk evaluation (Systematic COronary Risk Evaluation (SCORE) with increasing coefficient 1.5 for inflammatory diseases, Reynolds Risk Score (RRS), and the third modification of QRESEARCH Cardiovascular Risk Algorithm (QRISK3) were calculated. For the pts below 40 years old only QRISK3 was calculated.

Figure 1. Cardiovascular risk evaluation indices in patients with axial spondyloarthritis, n=118 for QRISK3, n=72 for SCORE and RRS.

Results: Mean age of the pts was 44.3±11.1 years; 91(77.1%) pts were males, HLA-B27 positive – 83 (70.3%) of the pts; mean disease duration 13.0±8.3 years. Mean value of SCORE was 2.78±1.89%, of RRS – 5.28±3.31%, of QRISK3 – 7.91±3.8% (figure 1). Cronbach's alpha for the scales was 0.873.

Figure 2. QRISK3 index in axSpA patients 25-40 years old, n=46

High CVR (≥5 %) was found in 14 (11.7%) of the pts according to the SCORE, in 65 (55.1%) of the pts according to the RRS, and in 81 (69%) of the pts according to the QRISK3. Ranking of CVR severity did not match in SCORE and QRISK3 indices in 83.72% of cases, in SCORE and RRS – in 51.16% of cases, and in QRISK3 and RRS in 8% of cases. The SCORE index showed the lower values of the expected risk as compared to the QRISK3 and RRS (figure 1). In axSpA pts at age 25-40 years old (n=46, mean age 32.6±4.0 years, males 36 (78.3%)), mean value of QRISK3 was 1.16±0.99 %; in 14 from 46 (30.4%) of those pts increased CVR was registered (figure 2).

Conclusion: There was a discrepancy in the severity of CVR calculated using different rating scales in axSpA patients. The SCORE index showed lower values of CVR as compared to the QRISK3 and RRS, which hypothetically could be the consequence of CVR underestimation. QRISK3 demonstrated the highest CVR and was the only index useful in pts below 40 years old. To exclude hyper- or underestimation of CVR calculation more data about CVR calculations and frequency of CV events, occurring in axSpA patients are needed.

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SAT0394 CAN FECAL CALPROTECTIN PREDICT FUTURE DEVELOPMENT OF INFLAMMATORY BOWEL DISEASE IN AXIAL SPONDYLOARTHRITIS PATIENTS? – TREASURE REAL-LIFE DATA

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Background: Patients with active inflammatory bowel diseases (IBD) fecal calprotectin (FC) levels are high and FC can be used for diagnosis [1].

Objectives: This study aimed to investigate whether fecal calprotectin levels could predict future development of IBD in axSpA patients.

Methods: This study was practiced in three centers using TREASURE database and that are able to measure FC. Fecal calprotectin levels were measured in 137 axSpA patients as of September 2018 and FC level ≥200 µg/g was considered significant. All study subjects were evaluated for IBD symptoms (loose defecation, mucous diarrhea, bloody defecation, bloody diarrhea, abdominal pain, obstruction, or pseudo-obstruction) at beginning of the study and every 3 months for the first year. 25 RA patients and 24 healthy volunteers were included as a control group. Disease activity was evaluated by the ASDAS CRP, BASDAI, BASFI, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), visual analog scale (VAS)-pain, VAS-fatigue, and tender and swollen joint count for axSpA patients.

Results: This study included 137 axSpA patients and all patients followed for 1 year. Of the 137 axSpA patients 33.6% were females and median (Q1-Q3) age was of 43 years (33-50 years), median (Q1-Q3) disease duration was 8.9 years (5.0-13.9 years). The median (Q1-Q3) fecal calprotectin level was 48 µg/g (30-122 µg/g) and FC level was ≥200 µg/g in 23/137 (16.8%) in axSpA patients. FC level was elevated in 15/24 (62.5%) RA patients and none of the healthy volunteers. Patients median (Q1-Q3) BASDAI was 2.2 (1.0-3.6) / 1.4 (0.4-2.2), median (Q1-Q3) BASFI 1.55 (0.4-3.4) / 1.5 (0.3-3.0) and median (Q1-Q3) ASDAS CRP 1.63 (1.3-2.2) / 1.5 (1.3-1.9) at baseline and first year respectively and there was no difference regarding fecal calprotectin level. In 1 year follow-up 9 (6.5%) patient had abdominal pain, 2 (1.4%) had bloody defecation, 1 (0.7%) had loose defecation and Crohn disease developed in an axSpA patient with high FC (266 µg/g) (Table 1). IBD occurrence rate was 0.73/100 patient-year for all SpA patients, and IBD occurrence rate was 4.34/100 patients year for SpA patients with ≥200 µg/g FC level.

Table 1. IBD symptom inquiry and development of IBD in the first year	
	n (%)
Loose defecation	1 (0.73)
Mucous diarrhea	0
Bloody defecation	2 (1.45)
Bloody diarrhea	0
Abdominal pain	9 (6.56)
Obstruction	0
Pseudo-obstruction	0
Inflammatory bowel disease	1 (0.73)