There was difference between US synovitis detection of upper (57.1%) and lower (42.9%) extremities (p=0.04). Total count of US enthesitis of lower extremities (70.4%) was significantly higher than of the upper (29.6%; p<0.01).

Conclusion: US synovitis of upper extremities was slightly higher than lower. US enthesis of lower extremities is significantly higher. US imaging can be used to diagnose enthesitis and synovitis, especially in patients in whom symptoms may be difficult to discern, and data on location of pathological lesions will be useful.

References:

Disclosure of Interests: None declared
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AB1092
ULTRASOUND EXAMINATION OF JOINTS AND PERIARTICULAR TISSUES IN PATIENTS WITH INFLAMMATORY BOWEL DISEASES.

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Background: Joints and enthesal involvement is a common extraintestinal manifestation in inflammatory bowel diseases (IBD).[1] Recent studies have shown the superiority of ultrasound over clinical findings in the evaluation of joints and periaricular tissues.

Objectives: To assess of joint and enthesal involvement in IBD patients using ultrasound with Power Doppler, their correlation with IBD clinical variables and the difference between Crohn’s disease (CD) and ulcerative colitis (UC).

Methods: We prospectively included 38 IBD patients into the study. Disease activity was evaluated in CD by Harvey Bradshaw index. Periarticular joints and entheses were imaged by ultrasound, using Samsung Acuvix A30 5-13 MHz linear array transducer. Ultrasound examination of 14 peripheral joints (hip, knee, ankle, shoulder, acromioclavicular, elbow, wrist) and 35 entheses was performed. Vascularization on them was assessed with Power Doppler (PD). Enthesal abnormalities were scored with US according to indices GUESS, MASEI and BUSIES.[2] Statistical analysis was done by Mann-Whitney test and Spearman criteria by “Statistica” software.

Results: In 38 patients UC was in 22 (58%), CD - in 16 (42%). The mean age of patients 29.9 ± 11.1 years in UC and 39.07 ± 11.7 years in CD. The male to female ratio in UC was 6:9, in CD was 6:10. The mean duration of disease was 6.9 ± 5.7 years in UC and 7.8 ± 7.5 years in CD. The rate of patients with active disease in UC was 55%, in CD was 50%. In UC patients the rate of patients with active disease (based on Power Doppler) was 50%, in CD was 34%. The rate of patients with active disease in UC was significantly higher than in CD (p = 0.03). The rate of patients with active disease in UC was significantly higher than in CD (p = 0.03). There was no significant difference in the rate of patients with active disease in UC and CD. The rate of patients with active disease in UC was significantly higher than in CD (p = 0.03).

Conclusion: Ultrasound examination of joints and entheses is a promising non-invasive imaging modality for the assessment of joint and enthesal inflammation in patients with IBD. Ultrasound imaging can help in the early diagnosis and monitoring of disease activity, and may be useful in the follow-up of patients with IBD.

References:

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2020-eular.5900

Table. Frequency of articular and enthesal involvement of different anatomical sites in PsA

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<thead>
<tr>
<th>Anatomical Site</th>
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<td>Patellar ligament</td>
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<td>Semimembranosus</td>
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<td>Tibialis posterior</td>
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<tr>
<td>Achilles</td>
<td>46/2166</td>
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<tr>
<td>Plantar fascia</td>
<td>30/2166</td>
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</table>

There was no significant difference in ultrasound signs of joint and entheses damage between patients with UC and CD.

We found an association between the clinical characteristics of IBD and the ultrasound signs of entheses damage: duration of the disease has a direct moderate correlation with the number of enthesitis (SR = 0.36; p = 0.028) and GUESS (SR = 0.37; p = 0.022).

Conclusion: The severity of joint and periarticular tissues damage is significantly correlated with the duration of the index disease and are independent of IBD activity.

References:

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AB1093
INTEROBSERVER AGREEMENT IN MAGNETIC RESONANCE FINDINGS OF SACRIOILIAC JOINTS ABOUT ACTIVE SACRIOILIITIS

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Background: Axial spondyloarthritids has characteristic clinical features such as enthesitis, sacroiliitis and spondylitis, and extra-articular manifestations(1). Magnetic resonance imaging (MRI) of sacroiliac (SI) joints is used to detect early sacroiliitis(2). Health institutions in our country carry out some of the radiology reporting services by outsourcing for reasons such as high cost and insufficient number of radiologists(3).

Objectives: We decided to evaluate the interobserver agreement in active MRI findings of SI between radiologist of outsourcing radiology services and local/expert radiologist in musculoskeletal diseases.

Methods: Between the years of 2015 and 2019, 8100 sacroiliac MRIs were taken at our center. The MRI of 1150 patients who were reported as active or chronic sacroiliitis from these sacroiliac MRIs or whose MRI was considered by the primary physician in favor of sacroiliitis was included in the study. Concordance between Evaluation and Service Procurement was examined using Kappa (k) coefficients. Mc Nemar test was used to compare the evaluation result between two observers. A p-value <0.05 was considered significant. Analyses were performed using commercial software (IBM SPSS Statistics, Version 23.0. Armonk, NY: IBM Corp.)

Results: Of the 1150 patients examined in the study, 526 (45.7%) were male and 624 (54.3%) were female. The general average age is 37.20 ± 11.65 and the average age of men and women is 34.89 ± 11.19 and 39.07 ± 11.71 respectively. A statistically significant difference was found between the expert radiologist and outsourcing radiologist reports. In other words, a high level of compatibility was not found among the evaluators (p <0.001). When the consistency between expert radiologist and outsourcing radiologist reports was examined, it was observed that there was a medium level of concordance (k = 0.589).

Conclusion: The diagnosis of a spondyloarthropathy may be delayed for some reasons. In addition to the insidious course of the disease, beingcontented with an outsourced radiologist report may delay diagnosis. If the patient’s clinical and MRI report are not consistent, the patient should not be removed from follow-up.

References:

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