spinal flexion and a contributory factor to tragus-to-wall distance and cervical rotation.

Conclusion: In early axSpA, spinal mobility impairment is independently determined by clinical disease activity, MRI spinal inflammation and the severity of enthesitis. Maximal intermalleolar distance (which is not a true measure of spinal mobility) was the only measure not associated with MRI spinal inflammation. The influence of spinal inflammation prevails in the early phase of axSpA while spinal damage becomes more relevant in later disease stages.

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OP0077

DETERMINANTS OF THE PHYSICIAN'S GLOBAL ASSESSMENT AND INFLUENCE OF CONTEXTUAL FACTORS IN EARLY AXIAL SPONDYLOARTHRITIS

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Background: In RMDs, the physician's global assessment (PhGA) is a major factor of treatment decision. It is not well-known which disease manifestations contribute to PhGA in early axSpA and if contextual factors have an impact.

Objectives: To investigate determinants of PhGA and the influence of contextual factors on this relationship in patients with early axSpA.

Methods: Five-year data from DESIR, a cohort of early axSpA, were analysed. Clinical data were collected every 6 months up to 2 years and annually thereafter. The primary analysis included all patients, and the subgroup analysis patients with follow-up MRI at 2 and/or 5 years. PhGA over 5 years was the outcome of interest. Univariable generalized estimating equation (GEE) models were used to investigate relationships between potential determinants and PhGA. Longitudinal relationships were investigated in autoregressive models. Effect modification by contextual factors (educational level, gender and age) was tested and, if significant, models were stratified. Univariable analyses were chosen to better assess the contributory explanatory effects of each of the determinants in each of the strata.

Results: A total of 708 patients were included, mean age 33.7 (SD 8.6) years, 46% male, 41% lower educated. The subgroup consisted of 220 patients with similar characteristics. Higher BASDAI questions 1-6, SJC28, TJC53, Maastricht Ankylosing Spondylitis Enthesitis Score (MASES), CRP and BASMI were associated with a higher PhGA (Table 1). Gender and age were effect modifiers of SJC28; the effect was largest in the younger male stratum (β [95% CI]: 1.07 [0.71, 1.43]), and smallest in the older female stratum (0.13 [0.04, 0.22]) (Figure 1). Autoregressive GEE models revealed the same determinants of PhGA and the same pattern of effect modification by gender and age.

Conclusion: Patient's subjective symptoms, peripheral arthritis, enthesitis, higher CRP and impaired spinal mobility contribute to explain PhGA in patients with early axSpA irrespective of gender and age. But physicians consider the presence of swollen joints as more important in males than in females.

Table 1. Factors associated with PhGA over time in gender/age-stratified groups in univariable analysis

	Female/Older (n=200)	Female/Younger (n=181)	Male/Older (n=154)	Male/Younger (n=173)
	Coefficient (95% CI)			
BASDAI Q1 (fatigue, 0-10)	0.39 (0.34, 0.44)	0.39 (0.34, 0.44)	0.41 (0.35, 0.46)	0.46 (0.41, 0.51)
BASDAI Q2 (back pain, 0-10)	0.49 (0.45, 0.54)	0.53 (0.49, 0.57)	0.48 (0.43, 0.53)	0.58 (0.54, 0.63)
BASDAI Q3 (peripheral joint pain, 0-10)	0.31 (0.27, 0.36)	0.36 (0.31, 0.41)	0.32 (0.27, 0.37)	0.43 (0.37, 0.48)
BASDAI Q4 (enthesitis, 0-10)	0.37 (0.33, 0.41)	0.42 (0.37, 0.46)	0.36 (0.31, 0.41)	0.52 (0.47, 0.56)
BASDAI Q5 (severity of morning stiffness, 0-10)	0.42 (0.37, 0.46)	0.45 (0.40, 0.49)	0.44 (0.40, 0.49)	0.58 (0.54, 0.63)
BASDAI Q6 (duration of morning stiffness, 0-10)	0.30 (0.25, 0.35)	0.35 (0.30, 0.39)	0.36 (0.31, 0.41)	0.50 (0.45, 0.56)
BASMI linear (0-10)	0.61 (0.45, 0.78)	0.67 (0.48, 0.86)	0.49 (0.30, 0.68)	0.95 (0.75, 1.15)
SJC28 (0-28)	0.13 (0.04, 0.22)	0.52 (0.31, 0.73)	0.58 (0.40, 0.76)	1.07 (0.71, 1.43)
TJC53 (0-159) ¶	0.05 (0.04, 0.06)	0.13 (0.11, 0.16)	0.13 (0.11, 0.16)	0.15 (0.13, 0.18)
MASES (0-39)	0.10 (0.08, 0.12)	0.15 (0.12, 0.17)	0.18 (0.14, 0.23)	0.30 (0.25, 0.35)
CRP (mg/L)	0.02 (0.01, 0.04)	0.03 (0.01, 0.05)	0.06 (0.04, 0.07)	0.04 (0.03, 0.05)
Any EAM (presence vs absence)	-0.13 (-0.49, 0.23)	-0.20 (-0.58, 0.19)	-0.26 (-0.68, 0.17)	-0.28 (-0.69, 0.14)
SPARCC-spine (0-414) §	0.06 (-0.11, 0.22)	0.05 (-0.11, 0.20)	0.02 (-0.03, 0.06)	0.05 (-0.04, 0.14)
SPARCC-SIJ (0-72) §	-0.02 (-0.13, 0.09)	0.01 (-0.08, 0.10)	0.05 (-0.01, 0.11)	0.01 (-0.04, 0.06)

¶ Each joint graded 0-3

§ Coefficients were estimated in the subgroup

Figure. Impact of swollen joint count on the physician's global assessment across gender and age groups

Regression coefficients (95% CI) of the effect of SJC28 on PhGA in the univariable GEE analyses across gender/age-stratified groups (in an ascending order).

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OP0078

MAPPING FROM THE ANKYLOSING SPONDYLITIS DISEASE ACTIVITY SCORE (ASDAS) TO EQ5D IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Clinical studies often omit outcomes that allow the direct estimation of Quality Adjusted Life Years (QALYs) for use in cost effectiveness analyses crucial for informing policy decisions. This means analysts often have to estimate the relationship, "map", between included outcomes and preference based ones like the EuroQoL EQ5D. In ankylosing spondylitis (AS), the relationship between BASDAI/BASFI and EQ5D has been established but the emergence and growing use of the Ankylosing Spondylitis Disease Activity Score (ASDAS), a new composite index used to assess clinical disease activity, means new mapping tools are required. Furthermore mapping has never been done for the entire axial