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FRI0390

IMPACT OF ULTRASONOGRAPHY-DETECTED QUADRICEPS CALCIFIC TENDONITIS ON PAIN AND FUNCTION IN PATIENTS WITH PRIMARY KNEE OSTEOARTHRITIS

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Background: Calcific tendonitis is most commonly seen around shoulder joint. Few cases of quadriceps calcific tendonitis (QCT) of were reported. Routine use of ultrasonography in diagnosis of knee osteoarthritis has resulted in detection of many cases of QCT.

Up to the best of our knowledge, this is the first study to detect impact of QCT in knee osteoarthritis by ultrasonography.

Objectives: To compare pain, function, and clinical and radiological findings among primary KOA patients with or without ultrasonography-detected QCT.

Methods: A prospective, observational study study was conducted on 214 patients with knee OA in the period between february 2019 to july 2019. Ultrasonography of knee joints was done according to EULAR guidelines. Quadriceps calcific tendonitis is defined as hyperechoic mass within the quadriceps tendon with posterior shadowing. The patients were categorized into two groups according to the presence or absence of QCT.

Radiological grades of Kellgren–Lawrence were recorded. Pain and functional status was assessed by visual analog scale (VAS), Health Assessment Questionnaire-II (HAQ-II), and Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)

Results: QCT were detected in 25 (11.6%) patients. Most cases of QCT were detected in vastus lateralis 18 (72%), then in vastus intermedius 5 (20%) and only 2 cases were detected in vastus medialis.

QCT were detected mainly in advanced stages of knee OA; 22 cases of QCT were found in patients with grade 4 KOA.

The presence of QCT was statistically significant related ($P < 0.05^*$) with age, VAS, HAQ-II, WOMAC subscales, synovitis and effusion.

Conclusion: Quadriceps calcific tendonitis is not rare. Ultrasonography can detect QCT in many cases with advanced knee OA. QCT is associated with increased pain and dysfunction in knee OA

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FRI0391

METABOLIC FACTORS ASSOCIATED TO RADIOGRAPHIC KNEE OSTEOARTHRITIS IN INDIVIDUALS WITH KNEE PAIN

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Background: Metabolic factors have been shown to be associated to radiographic knee osteoarthritis (OA) [1]. More knowledge about associations between metabolic factors and early clinical knee OA is needed.

Objectives: The aim was to study associations between metabolic factors and radiographic knee OA in individuals with knee pain

Methods: In total 272 individuals with radiographs at baseline, from an ongoing longitudinal study of knee pain (without cruciate ligament injury), were included in the present cross-sectional study. At baseline BMI, waist circumference (WC) and visceral fat area (VFA) were assessed. Fasting plasma glucose, triglycerides, cholesterol, HDL- and LDL-cholesterol were analysed. Metabolic syndrome (MetS) was present if central obesity (WC ≥ 94 cm in men and ≥ 80 cm in women)

plus any two of the following factors: raised blood pressure (systolic blood pressure ≥ 130 or diastolic blood pressure ≥ 85 mm Hg or treatment of hypertension), raised triglycerides (≥ 1.7 mmol/L or specific treatment), reduced HDL-cholesterol (men < 1.03 mmol/L and women < 1.29 mmol/L or specific treatment), raised glucose (glucose ≥ 5.6 mmol/L, or type 2 diabetes).

The individuals were divided in two groups according to Ahlback [2], one group, who had grade I or more in at least one knee (radiographic knee OA, ROA) $n=62$ and the other group, not fulfilling Ahlback criteria (no radiographic knee OA, No OA) $n=211$. The associations between metabolic factors and knee OA were calculated by crude logistic regression analyses, adjusting for age and sex.

Results: The group with radiographic knee OA were older, had higher BMI, higher amount of visceral fat and more had central obesity, table 1. Ninety- four percent of the group with ROA had central obesity compared to 76%, $p=0.002$ in the no OA group. There was no difference between the groups regarding MetS, 44% in the ROA group vs. 39%, $p=0.5$. The group with ROA had increased cholesterol, triglycerides and LDL-cholesterol. There were no differences in fasting glucose between the groups, though both groups had a mean glucose value in the upper range of normal value, table 1. Factors associated to having radiographic knee OA were age (OR 1.11, 95% CI 1.06-1.17), BMI (1.07, 1.003-1.13), central obesity (3.91, 1.32-11.61) and raised triglycerides (2.35, 1.03-5.38).

Table 1. Baseline descriptives

	No OA Mean (sd)	ROA Mean(sd)	p-value
N	211	62	
Age	50 (9)	56 (4)	<0.001
Sex, women, %	66	71	0.454
BMI	25.9 (4.7)	27.7 (4.7)	0.007
VFA (cm ²)	109 (53)	126 (52)	0.026
WC, cm	94 (13)	99 (13)	0.006
Raised Blood pressure, %	66	53	0.063
Cholesterol (mmol/L)	5.2 (1.0)	5.5 (1.1)	0.033
Triglycerides (mmol/L)	1.0 (0.6)	1.2 (0.7)	0.035
Raised triglycerides, %	9	21	0.008
LDL-cholesterol (mmol/L)	3.4 (1.0)	3.7 (1.1)	0.027
HDL-cholesterol (mmol/L)	1.7 (0.4)	1.7 (0.5)	0.547
Reduced HDL	11	15	0.460
Glucose (mmol/L)	5.5 (0.9)	5.5 (0.5)	0.858

Conclusion: There were associations between some metabolic factors and radiographic knee OA in individuals with knee pain. Fasting glucose was increased in both groups. The associations between metabolic risk factors and the development of knee OA needs to be assessed in longitudinal studies.

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FRI0392

ADVERSE EVENTS IN PATIENTS WITH OSTEOARTHRITIS TREATED WITH SUBCUTANEOUS TANEZUMAB: A POOLED ANALYSIS OF THE OVERALL POPULATION AND SELECTED SUBGROUPS FROM 3 RANDOMISED PLACEBO-CONTROLLED TRIALS

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Background: Tanezumab, a monoclonal antibody against nerve growth factor (NGF), is in development for the treatment of osteoarthritis (OA).

Objectives: To assess the effects of gender, age and body mass index (BMI) on the incidence of adverse events (AEs) in patients (pts) treated with subcutaneous (SC) tanezumab in pooled data from three phase 3 OA studies. Anti-NGF therapy has been associated with joint safety events¹. Here we focus on treatment emergent AEs, including abnormalities of peripheral sensation (APS).

Methods: All three randomised, double-blind, placebo-controlled studies enrolled pts with radiographically-confirmed OA of the hip or knee, who had inadequate response or could not tolerate standard of care analgesics. In the 16-week (wk) Study 1 (NCT01089725), pts received placebo, tanezumab 2.5 mg, 5 mg or 10 mg at baseline and wk 8². Due to a clinical hold on NGF antibodies, <10% of pts received the 2nd dose at wk 8. Pts in the 16-wk Study 2 (NCT02697773), received placebo or tanezumab 2.5 mg at baseline and wk 8 or tanezumab 2.5 mg at baseline and 5 mg at wk 8¹. Pts in the 24-wk Study 3 (NCT02709486), received