Results: 217 IBD patients were included in the study. Twenty patients with previously known rheumatologic diseases were excluded from the study. 49 (24%) of the remaining 197 patients had a positive answer to at least one question in the DETAIL query. 39 (20%) of these patients were evaluated in the rheumatology clinic, and 16 (8.1%) of them were diagnosed with SpA (spondylitis: 9, peripheral arthritis: 7) (Figure 1). There were no significant differences in terms of age, gender, IBD type, duration of IBD, current treatment, fibromyalgia syndrome (FMS) and depression according to Beck depression inventory between patients with IBD with and without SpA (Table 1).

Table 1. Clinical, demographic characteristics of the IBD patients according to SpA.

	IBD with SpA n= 16	IBD without SpA n= 23	p
Age, years, median (IQR)	47.03 (27.4)	35.9 (14.1)	0.052
Female, n (%)	8 (50)	17 (74)	0.12
IBD disease duration, months, median (IQR)	66.7 (70.7)	44.8 (70)	0.26
IBD type, n (%)			
CD	6 (37)	11 (48)	0.19
UC	9 (56)	12 (52)	
IC	1 (7)		
Smoking (ever), n (%)	10 (62.5)	11 (48)	0.37
HLA-B27 positivity, n (%)	2 (12.5)	1 (4.3)	0.57
Current medication, n (%)			
- Steroid (oral and/or topical)	6 (37.5)	5 (21.7)	0.31
- 5-ASA	11 (68.8)	14 (61)	0.61
- Immunosuppressants (AZA, MTX)	6 (37.5)	8 (34.8)	0.86
- bDMARD	2 (12.5)	4 (17.4)	1
FMS, n (%)	1 (6.7)	3 (13)	1
Beck depression Inventory, level of depression, n (%)			
-minimal	1 (9)	5 (22)	0.13
-mild	8 (73)	7 (30)	
-moderate	2 (18)	9 (39)	
-severe	0	2 (9)	

Harvey-Bradshaw Index for CD disease activity and Mayo score for UC disease activity were used. **SD:** standard deviation, **IQR:** inter-quartile range **IBD:** inflammatory bowel disease; **SpA:** Spondyloarthritis, **bDMARD:** biological disease modifying anti-rheumatic drug, **CD:** Crohn's disease, **UC:** Ulcerative colitis, **IC:** indeterminate colitis; **HBI:** Harvey-Bradshaw Index **ASA:** 5-aminosalicylic acid; **AZA:** azathioprine; **MTX:** methotrexate; **FMS:** Fibromyalgia syndrome

Conclusion: By questioning the musculoskeletal system in IBD patients, 20% of the patients were evaluated in the rheumatology department, and nearly half of these patients (8%) were diagnosed with SpA. The findings point to the importance of musculoskeletal symptom questioning in routine outpatient clinic control in IBD patients.

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Figure 1 Flow chart of IBD patients in the study

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AB0492

DETERMINING FACTORS RELATED TO POOR QUALITY OF LIFE IN PATIENTS WITH SPONDYLOARTHRITIS: A REAL LIFE STUDY

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Background: When treating people with spondyloarthritis (SA), rheumatologists are focused on reducing disease activity based on activity measurement scores; but there may be other factors not directly captured by these tools, which impact on quality of life.

Objectives: We aim to identify factors associated with poor quality of life in patients with spondyloarthritis.

Methods: A cross-sectional study was performed in 100 patients with spondyloarthritis. Data on sociodemographic and disease characteristics were collected as well as specific scores: Visual analogue scale (VAS) for fatigue and pain, Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Ankylosing Spondylitis Disease Activity Score with CRP (ASDAS-CRP), Bath Ankylosing Spondylitis Function Index (BASFI) and Bath Ankylosing Spondylitis Metrology Index (BASMI). EuroQol-5D (EQ5D) was used to assess health-related quality of life.

Results: A total of 100 Patients were enrolled (73 men and 27 women); the mean age was 43.68 ± 10.3 years. Thirteen percent of patients had high level of education (> 12 years), 47% had BMI ≥ 25 and 47% were smoking. Sixty seven percent of patients had ankylosing spondylitis, 17% had rheumatism associated with inflammatory bowel disease and 16% had psoriatic rheumatism. The average disease duration was 12.24 ± 8.73 years. Mean age at onset was 33.2 ± 10 years. The average diagnostic delay was 2.41 ± 3 years. Sacroiliac pain has been noted in 69 patients, lumbar or cervical stiffness in 78 patients and peripheral joint involvement in 18 cases. Thirty one percent of patients had hip joint involvement and 49% had extra-articular manifestation. Fifty percent had inflammatory biological syndrome, 63% were treated with anti-TNF α and 58% needed symptomatic treatment regularly. The mean fatigue and pain VAS was respectively 5.58 ± 2.5 and 5.56 ± 2.9 . The mean BASDAI was 4.4 ± 2.4 , the average BASFI was 4.6 ± 2.7 and the average ASDAS-CRP was 2.77 ± 1.18 . The mean BASMI was 4.4 ± 2.8 . EQ5D questionnaire showed that: 37 patients had no problems with mobility, 61 had some problems and two had extreme problems; 39 patients had no problems with self-care, 55 had some problems and six had extreme problems; 35 patients had no problems with performing usual activities, 60 had some problems and five had extreme problems; 13 patients had no pain or discomfort, 61 had moderate pain or discomfort and 26 had important pain or discomfort; 42 patients had no anxiety or depression, 46 had moderate anxiety or depression and 12 had extreme anxiety or depression. The mean EQ5D score was 0.485 ± 0.378 [-0.448-1] and the mean general health EQ5D VAS was $59 \pm 25\%$ [7-100]. Poor quality of life was associated with smoking ($p=0.03$), physical inactivity ($p<0.001$), cervical and lumbar stiffness ($p=0.001$), peripheral joint involvement ($p=0.006$), inflammatory biological syndrome ($p<0.001$), need of symptomatic treatment ($p<0.001$), BASDAI > 4 ($p<0.001$), ASDAS > 2.1 ($p<0.001$), BASFI > 4 ($p<0.001$) and BASMI > 4 ($p<0.001$).

Conclusion: Active disease and reduced physical function are the main causes of poor quality of life in patients with spondyloarthritis. Good disease management, smoking cessation and encouragement of physical activity can potentially improve patients' quality of life.

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AB0493

WHAT IS THE DIAGNOSTIC VALUE OF IMPAIRED SPINAL MOBILITY MEASUREMENTS IN INFLAMMATORY BACK PAIN PATIENTS? DATA FROM THE DESIR COHORT

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Background: The diagnostic process in a patient with early inflammatory back pain suggestive of axial spondyloarthritis (ax-SpA) requires assessment and integration of multiple aspects, including clinical examination, biological measurements and radiologic assessments. Among the physical examination features, alteration of spinal mobility is often observed in ax-SpA. However,

whether mobility impairment might really increase diagnostic likelihood, and which of the measurements made have relevant diagnostic value remains unknown.

Objectives: To describe the frequency and severity of mobility impairment in multiple traditional measurements in patients suspect of early ax-SpA at initial assessment time, and to analyze their individual diagnostic performances in reference to usual classification criteria applied after 2 years of follow-up.

Methods: Data from the DESIR cohort, which included patients aged 18-50 with inflammatory back pain lasting for 3 months to 3 years and a clinical suspicion of ax-SpA diagnosis were used. Baseline measurements of Schober's test (Schober), chest expansion (CEX), lateral spinal flexion (LatSpiFlex), cervical rotation (CervRot) and intermalleolar distance (IntMalDist) collected at baseline were classified according to reference data from the general population adjusted for age and -when appropriate- for height. Cutoffs were defined as above 2.5th, 5th, 10th and 25th percentiles. With ASAS classification for ax-SpA applied at 2 years follow-up visit as external reference, diagnostic performances (Sensitivity [Se], Specificity [Sp], Positive [PPV] and Negative [NPV] Predictive Values) were calculated.

Results: Complete data were available for 575 patients (of whom 377 (66%) fulfilled the ASAS criteria at 2 years). Schober, CEX, LatSpiFlex, CervRot and IntMalDist were above 5th percentile in respectively 278 (48%), 82 (14%), 220 (38%) and 93 (16%) patients. None of the measurements showed a clinically relevant compromise between both Se and Sp, but Sp was highest for CEX-most impaired cutoffs (Figure 1). The highest PPV (73.6%) and NPV (39.4%) were observed for LatSpiFlex.

Conclusion: Measures of mobility and their levels of impairment do not show sufficient individual diagnostic value for ax-SpA among patients with early inflammatory back pain. However, highest degrees of impairment when compared to general population are more specifically observed in patients finally classified with ax-SpA for CEX, which was –consistently- 1 of the 2 mobility measures that was retained in the modified New York criteria for ankylosing spondylitis.

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AB0494

COGNITIVE IMPAIRMENT IN AXIAL SPONDYLOARTHRITIS?

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Background: There is some evidence that neuropsychiatric changes occur in systemic lupus(1) and rheumatoid arthritis(2). However, little is known regarding a possible disease-related impairment of cognitive abilities in axial spondyloarthritis (axSpA).

Objectives: To evaluate patients with axSpA regarding cognitive impairments.

Methods: Patients with axSpA attending two rheumatology practices were routinely evaluated by rheumatologists and underwent a computer-based memory and attention test (MAT) (3, 4) with subscale scores ranging from 0 (worst) to 15 (best). The results of short-term memory and working memory were compared to an age-, sex- and education-matched control group of healthy subjects. Descriptive results are presented as median (IQR) for interval data and n (%) for nominal data if not stated otherwise. Two-tailed Wilcoxon signed-rank tests including Bonferroni-Holm adjustment for multiple tests were conducted to investigate the magnitude of potential differences in cognitive abilities.

Results: 101 consecutive patients were tested (Table 1). After multiple testing adjustment for two subscales, Wilcoxon signed-rank tests returned significant findings for working memory (V = 539.5, p = 0.006, Irl = 0.204) but not for short-term memory (V = 1075, p = 0.351, Irl = 0.078). Regarding the scales' anchors, descriptive results on pairwise differences suggested axSpA patients to have working memory scores that are on average 10.7% lower compared to control participants (mean Δ = -1.64, SD Δ = 5.95).

Table 1. Patients and disease characteristics

	n	%	Mean	SD	Median	25% Quantile	75% Quantile
Age	101	100	51.1	11.6	52	42	60
Age (female)	48	47.5	52.6	11.7	54	44.5	61
Age (male)	53	52.5	49.8	11.5	51	41	57
< 13 years formal education	47	46.5					
≥ 13 years formal education	54	53.5					
HLA B27 positive n/N	64/92	63.4					
Disease duration (years)	101	100	13.7	11.7	12	4	21
Disease duration (female, years)	48	47.5	11.6	9.9	9	4	17.2
Disease duration (male, years)	53	52.5	15.5	12.9	15	5	23
BASDAI	92	91.1	3.7	1.7	3.8	2.4	5
BASFI	91	90.1	3	2.4	2.3	1.2	4.5
BASMI	75	74.3	1.9	2.3	1	0	3
ASDAS	98	97	2.3	0.8	2.3	1.8	2.8

Conclusion: The MAT computerized testing is a feasible test and was well accepted by patients. Results regarding working memory suggest that cognitive abilities needed to accomplish everyday tasks may be impaired in axSpA patients. Further work is needed to characterise possible causes of or associations with this cognitive impairment.

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