patients who were intraarticular introduced HA with HS. The course of IA injections was 2 for LMW, HMW, and HA with HS, and 3 for MMW HA. Injections were performed with an interval of 1 week. To evaluate the results of treatment, we studied the intensity of pain according to VAS and the total score of KOOS before treatment and on follow-up examinations 1, 3 and 6 months after the course of IA HA injections.

Results: the maximum reduction in pain with IA HA injections at stage I of knee OA occurred by 3 months after the course of treatment. Moreover, improvement was detected by 1 month in 84.3% of cases, and remained until the end of the study in 71.1% of patients. All HA preparations used in stage I of knee OA were effective. At stage II of the knee OA after 3 months after the course of IA HA, different efficiencies of HA preparations were revealed. So, in the groups of LMW, MMW and HA with HS, the improvement persisted up to 3 months, and in the group of HMW HA - up to 1 month. After 3 months, the best results were shown by HA with HS, by 6 months the results were comparable. IA HA injections at the II stage of knee OA led to good and excellent results 1 month after the course of treatment in 53.9% of cases, but by the end of the study, improvement remained in only 30.8% of patients. In the case of the use of HA in stage III of the knee OA, the effectiveness of the studied drugs was comparable, and the maximum improvement was achieved by 1 month. The positive effect of IA HA injections in patients with stage III of the knee OA one month after the course of treatment was obtained in 40.6% of cases, by 3 months it decreased to 18.8%, and by 6 months - to 15.7% of patients.

Conclusion: IA injections of HA at stage I of the knee OA is a highly effective method of conservative treatment, which allows to relieve pain and improve the condition of the knee joint for a period of 6 months or more. The use of HA preparations at stage II of the knee OA allows reducing pain up to 3 months with IA injections of LMW and MMW HA, as well as HA with HS. HMW HA helps reduce pain intensity for a period of 1 month. The use of HA preparations in stage III of the knee OA leads to a short-term relief of symptoms of OA.

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.485

AB0586

PREVALENCE OF EARLY SYMPTOMATIC KNEE OSTEOARTHRITIS ACCORDING TO THREE CLINICAL CLASSIFICATION CRITERIA

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Background: Knee osteoarthritis (KOA) is a heterogeneous disease. Different classification criteria for symptomatic KOA (SKOA) have been proposed. Determining the prevalence and comparing the different criteria of SKOA in patients with knee pain will serve as a base when studying the predictive ability of these criteria in a longer perspective.

Objectives: To study the prevalence of SKOA in individuals with knee pain according to three different classification criteria: the American College of Rheumatology (ACR), (1), the European League Against Rheumatism (EULAR)(2), and the National Institute for Health and Care Excellence (NICE) (3).

Methods: Baseline data from an ongoing longitudinal study (HALLOA) including 296 individuals with knee pain, recruited by advertisement, were analysed. The individuals were categorized according to the classification criteria of SKOA (ACR, EULAR and NICE) based on age, clinical examination (crepitation), and self-reported data from KOOS (pain, symptoms, ADL, and sport/recreation), and dichotomized as fulfilling the criteria (SKOA) or not (no SKOA). BMI was measured (kg/m²). Radiographic KOA (RKO) was assessed according to Ahlback criteria (1-5), defined as RKO with grade 1 or more in at least one knee. Prevalence was calculated (frequencies, %) for each criterion, and Chi-Square test or the Independent-Samples t-test were used for comparisons between individuals fulfilling SKOA or not.

Results: The mean age was 52 (min-max 24-73) years, 70% were women and 22% were classified with RKO. The prevalence of SKOA according to each criterion was 57% (ACR), 51% (EULAR) and 73% (NICE) respectively. In total, 48% had SKOA according to all three criteria and whereof 32% had RKO, compared to 10% RKO among individuals with no SKOA. Regardless of the criterion, significantly more individuals classified with SKOA also had RKO compared to

individuals with no SKOA, $p < 0.001$. Those classified as SKOA were significantly older and had higher BMI compared with no SKOA (Table 1).

Conclusion: Approximately 50-70% of the individuals with knee pain were classified as having SKOA, where EULAR criteria had the lowest prevalence. A better understanding of early knee pain classification according to different clinical criteria is essential for the ability to capture and follow the long-term prognosis of early SKOA. Further longitudinal studies are needed.

REFERENCES:

[1] Altman R et al. Arthritis Rheum. 1986;29(8):1039-49.

[2] Zhang W et al. Ann Rheum Dis. 2010;69(3):483-9.

[3] Health Nif, Excellence C. UK: National Institute for Clinical Excellence. 2014.

Table 1. Comparisons between the ACR, EULAR and NICE criteria of symptomatic knee osteoarthritis, stratified by symptomatic knee osteoarthritis or not

	ACR			EULAR			NICE		
	Total	OA	No OA	P-value	OA	No OA	P-value	OA	No OA
N (%)	296	170	98		152	114		215	58
	(100)	(57.4)	(33.1)		(51.4)	(38.5)		(72.6)	(19.6)
Age (Y), Mean (SD)	51.6	53.3	49.0	<0.001	54.5	48.1	<0.001	54.7	40.5
	(8.7)	(7.0)	(10.3)		(5.1)	(10.8)		(4.9)	(9.8)
Gender, female (%)	208	121	66	0.511	108	77	0.538	154	36
	(70.3)	(71.2)	(67.3)		(58.4)	(67.5)		(71.6)	(62.1)
BMI (kg/m ²), Mean (SD)	26.4	26.5	25.8	0.179	26.9	25.4	0.005	26.7	24.8
	(4.6)	(4.5)	(4.3)		(4.5)	(4.2)		(4.5)	(3.8)
RKO, n (%)	64	45	12	0.003	47	10	<0.001	58	1
	(21.6)	(26.5)	(12.2)		(30.9)	(8.7)		(27.0)	<0.001

Independent-samples t-test and Chi-2-test. **Bold**=Significant correlation ($p \leq 0.05$). **OA** = Osteoarthritis. **ACR** = American College of Rheumatology. **EULAR** = the European League Against Rheumatism. **NICE** = the National Institute of Care and Excellence. **BMI** = Body Mass Index. **RKO** = Radiographic Knee Osteoarthritis (Ahlback, with grade ≥ 1 in ≥ 1 knee).

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.520

AB0587

ASSESSING THE CHARACTERISTICS AND MANAGEMENT OF KNEE OSTEOARTHRITIS PATIENTS WITH HYPERTENSION BY CLINICIAN SPECIALITY

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Background: Though the pathogenesis of knee osteoarthritis (OA) is complex, patients with OA frequently have other comorbidities, including hypertension, which eludes to other considerations needed when deciding appropriate treatment management.

Objectives: This study aims to examine the profiles of knee OA patients with hypertension vs. those without any comorbidities, and to elucidate key differences between these patient groups as potential areas of consideration.

Methods: A multi-center, online medical chart review study of patients with OA was conducted between May – July 2020 among US rheumatologists (rheums), orthopedic surgeons (orthos), primary care physicians with a focus in sports medicine (SM PCPs), and pain specialists. Physicians recruited were screened for duration of practice in their specialty (3-50 years) and caseload (≥ 35 knee OA patients personally managed, at least 10 being moderate-severe). Patient charts were recorded for the next 5 eligible patients seen during the screening period. Respondents abstracted patient demographics and treatments used. Descriptive statistics were used to analyse the data.

Results: 260 physicians were recruited and collectively reported 796 knee OA patients; 559 were reported to experience hypertension whilst 237 were reported as not experiencing any comorbidities.

Reported hypertension patients were significantly older (mean 67 vs 59 years old, respectively; $p \leq 0.01$) and weighed more (mean 82kg vs 77kg, respectively; $p \leq 0.01$) than patients without comorbidities; they were also significantly more likely to be previous smokers compared to those without comorbidities (23% vs 8%, respectively; $p \leq 0.01$). With regards to current knee OA severity, both orthos and SM PCPs reported a significantly higher proportion of hypertension patients that were deemed 'severe' (physician opinion) vs patients without comorbidities (orthos: 50% vs 32%, respectively; SM PCPs: 42% vs 23%, respectively; $p \leq 0.01$). Rheums and pain specialists reported greater mild opioid usage amongst hypertension patients compared to those without comorbidities (rheums: 28% vs 10%, respectively ($p \leq 0.05$); pain specialists: 40% vs 9%, respectively; ($p \leq 0.01$)); orthos and SM PCPs stated significantly greater use of corticosteroid injections amongst their reported hypertension patients vs those without comorbidities (orthos: 60% vs 41%, respectively; SM PCPs: 40% vs 19%, respectively; $p \leq 0.01$). Hypertension patients reported by orthos and SM PCPs are more likely to be