Conclusion: The diagnostic value of a single diagnostic test in the clinical practice is not fixed and a number of factors including the referral pathway can affect it. Fluctuation of the diagnostic values is especially relevant when the number of positive parameters is low (1-2).

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OP0049

COMPARISON OF BASELINE DISEASE ACTIVITY AND PATIENT (PT)-REPORTED OUTCOMES (PROS) BETWEEN PTS WITH PSORIATIC ARTHRITIS AND AXIAL INVOLVEMENT (AXIAL PSA) AND AXIAL SPONDYLOARTHRITIS (AXIAL SPA) FROM THE CORRONA PSA/SPA REGISTRY

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Background: Although pts with axial PsA and axial SpA share some common clinical characteristics, there are also potential differences that may influence disease assessment and treatment response. Identifying differences between the two pt populations is important for assessment of disease characteristics and severity as well as informing treatment decisions. There has been little comparative characterization of these conditions in a US population.

Objectives: To compare characteristics of pts with axial PsA and axial SpA.

Methods: Pts ≥18 years of age diagnosed with axial PsA or axial SpA at enrollment in the prospective, multicenter, observational Corrona PsA/SpA Registry between March 2013 and August 2020 were included. Enrollment visit demographics, clinical characteristics, treatment history, disease activity measures, and PROs were compared between disease groups. Continuous measures were reported using means and standard deviations; means for disease groups were compared using two-sample *t* tests or Wilcoxon rank sum tests. Categorical measures were reported as frequencies and percentages; frequencies in disease groups were compared using chi-square or Fisher exact tests.

Results: A total of 1044 pts (470 with axial PsA and 574 with axial SpA) were identified (Table). Pts with axial PsA were older with a higher percentage being female vs pts with axial SpA. Time since symptom onset and diagnosis were shorter for pts with axial PsA vs axial SpA (12.0 vs 15.6 years [*P*<0.001] and 6.8 vs 8.3 years [*P*=0.01]). Pts with axial PsA were less likely than pts with axial SpA to have current or historical uveitis (4% vs 14% [*P*<0.001]) or inflammatory bowel disease (5% vs 10% [*P*=0.005]). Prior biologic synthetic disease-modifying antirheumatic drug (bDMARD) and conventional synthetic DMARD use was more prevalent in the axial PsA vs axial SpA groups (64% vs 52% [*P*<0.001]/59% vs 32% [*P*<0.001]), while mean dactylitis (measured by Dactylitis Count) and enthesitis (measured by Spondyloarthritis Research Consortium of Canada [SPARCC] Enthesitis Index) counts were higher (0.4 vs 0.1 [*P*<0.001]/1.7 vs 1.2 [*P*<0.001]). Mean pt-reported pain and spinal pain were lower in pts with axial PsA vs axial SpA (49.4 vs 53.9 [*P*=0.015]/40.8 vs 49.7 [*P*<0.001]) (Figure). The proportion of pts with morning stiffness along with mean fatigue and work impairment scores were similar between disease groups.

Table.

Baseline demographics and clinical characteristics	Axial PsA N=470	Axial SpA N=574	P value
Age (years), mean ± SD	51.6 ± 13.2	47.7 ± 14.0	<0.001
Female, n (%)	265 (57)	248 (44)	<0.001
White, n (%)	428 (94)	507 (91)	0.089
Years since symptom onset, mean ± SD	12.0 ± 11.6	15.6 ± 12.1	<0.001
Years since diagnosis, mean ± SD	6.8 ± 9.0	8.3 ± 10.5	0.010
HLA-B27 positive status, n/n (%)	52/189 (28)	214/295 (73)	<0.001
Abnormal CRP, n (%)	88 (19)	140 (24)	0.033
Uveitis, n (%)	20 (4)	80 (14)	<0.001
IBD, n (%)	25 (5)	59 (10)	0.005
Dactylitis count, mean ± SD	0.4 ± 1.5	0.1 ± 0.7	<0.001
SPARCC enthesitis count, mean ± SD	1.7 ± 2.9	1.2 ± 2.4	<0.001
Morning stiffness, n (%)	439 (95)	537 (96)	0.923
BASDAI (0–10), mean ± SD	4.8 ± 2.5	4.9 ± 2.4	0.463
BASDAI Q2 (0–10): spinal pain, mean ± SD	5.0 ± 2.9	5.7 ± 2.9	<0.001
BASDAI Q3 (0–10): peripheral pain/swelling, mean ± SD	4.5 ± 2.9	4.0 ± 3.1	0.010
Modified BASDAI (0–10), mean ± SD	5.0 ± 2.5	5.4 ± 2.4	0.013
Prior bDMARDs, n (%)	300 (64)	299 (52)	<0.001
Prior csDMARDs, n (%)	275 (59)	181 (32)	<0.001
Prior prednisone use, n (%)	54 (12)	73 (13)	0.611
Prior NSAID use, n (%)	52 (11)	46 (8)	0.115

Conclusion: Findings from this descriptive real-world analysis suggest there may be meaningful differences between pts with axial SpA and axial PsA and future studies are needed to better understand these differences.

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Figure. Patient-reported outcomes*

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OP0050

TWO-YEAR DIAGNOSTIC CONSISTENCY IN PATIENTS WITH CHRONIC BACK PAIN SUSPECTED OF AXIAL SPONDYLOARTHRITIS IN PROTOCOLISED FOLLOW-UP: DATA FROM THE SPONDYLOARTHRITIS CAUGHT EARLY COHORT

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Background: A diagnosis of (early) axial spondyloarthritis (axSpA) is based on pattern recognition, which can be challenging and may change over time.

Objectives: To investigate consistency of diagnosis over two years in patients with chronic back pain (<2 years symptoms) suspected of axSpA.

Methods: In the SPACE cohort, patients over 16 years of age referred to the rheumatology outpatient clinic with chronic back pain (CBP) (≥3 months and <2 years) starting before the age of 45, suspected of axSpA were included. Follow-up was performed only in patients with at least two SpA features or one SpA feature with a positive likelihood ratio ≥6.4¹.

According to protocol, all SpA features as well as MRI and radiographs of the sacroiliac joints were performed at baseline and two years. Physicians were asked to report whether the diagnosis was axSpA or no axSpA at both time-points, for which they had information available on all SpA features and locally