Conclusion: Presence of HLA-B27 in pSpA patients was associated to a higher axial and root joint involvement, an earlier disease onset and presence of AAU, but not to PsA, psoriasis and IBD that were higher in HLA-B27 negative patients.

Table 1.

	HLA-B27+ (N = 118)		HLA-B27- (N = 168)		p
	N/mean	%/SD	N/mean	%/SD	
Obesity (BMI >30)	14	11,9%	44	26,3%	0,003
Men	65	55,1%	83	49,4%	0,344
Family history	44	37,3%	52	31,0%	0,265
Axial involvement	62	52,5%	42	25,0%	<0,001
Radiographic sacroiliitis	30	28,3%	25	16,8%	0,029
Psoriatic arthritis	23	19,5%	112	72,6%	<0,001
Reactive arthritis	5	4,2%	3	1,8%	0,229
IBD arthritis	1	0,9%	8	4,8%	0,098
Mono/oligoarticular pattern	59	54,6%	76	51,0%	0,566
Root joint involvement	52	44,1%	54	32,1%	0,04
Tarsitis	22	18,6%	16	9,5%	0,028
Enthesitis	62	52,5%	69	41,1%	0,056
Dactylitis	31	26,3%	51	30,4%	0,452
Peripheral structural damage	9	7,6%	41	24,4%	<0,001
Psoriasis	21	17,8%	125	74,4%	<0,001
AAU	21	17,8%	7	4,2%	<0,001
IBD	2	1,7%	13	7,7%	0,039
Fibromyalgia	15	13,2%	43	26,7%	0,008
Age (y)	42,7	14,8	52,2	13,4	<0,001
Age onset (y)	33,9	13,7	38,3	14,5	0,013
Dx delay (m)	4,7	8,2	7,7	9,8	0,009
Disease duration (y)	9,06	10,2	14,2	11,6	<0,001
BASDAI	3,9	2,2	4,4	2,4	0,06
CRP	16,9	25,1	12	27,3	0,148
ASDAS-CRP	2,7	1,2	2,7	1,1	0,876
AAU number of episodes	6,8	8,4	2,1	1,7	0,265

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POS0243

WHAT DOES REMISSION IN AXIAL SPONDYLOARTHRITIS MEAN FOR CLINICIANS? AN EXPLORATORY STUDY OF 200 FRENCH RHEUMATOLOGISTS BASED ON A VIGNETTE EXERCISE INCLUDING 36 CASES AND PRIORITY RATINGS

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Background: Treat-to-target in axial spondyloarthritis (axSpA) aims to achieve and maintain clinical remission/inactive disease or alternatively, low disease activity [1]. However, there is no consensual definition of remission in axSpA: the T2T international task force has proposed Ankylosing Spondylitis Disease Activity Score (ASDAS) inactive disease, but this definition is not widely accepted [1, 2].

Objectives: To explore rheumatologists' perception of remission in axSpA, using vignette cases and a priority exercise.

Methods: A steering group of 7 rheumatologists designed a national cross-sectional survey during two face-to-face meetings in 2019-2020. The survey comprised 36 vignette cases: fixed elements included the clinical picture (34 year-old-male with confirmed axSpA, normal C-reactive protein (CRP), without synovitis, enthesitis, dactylitis or extra-articular manifestations) and there were 3 varying parameters (axial pain (0-10) [ranging 2 to 5], fatigue (0-10) [2 to 8], and morning stiffness [<15 minutes, 30 minutes or 1 hour]). For each vignette, the rheumatologist answered binarily: "do you consider this patient in remission: yes/no". The second part of the survey comprised a priority rating (0-10 priority and 4

top items) of elements important to consider for remission, from a list of 12 items (BASDAI, ASDAS, elements of BASDAI and ASDAS including CRP, NSAIDs use, extra-articular manifestations, and other explanations for the symptoms e.g., fibromyalgia). The analysis was descriptive.

Results: Overall, 200 French rheumatologists participated between June and September 2020. Out of 2,400 vignette evaluations (mean of 66 evaluations per vignette), 463 (19%) were classified as remission by rheumatologists. Six vignette cases constituted 56% of all remission cases (Figure 1): these comprised a short duration of morning stiffness (<15 minutes), a low VAS axial pain (2 or 3) but with varying levels of VAS fatigue. When the duration of morning stiffness increased from 15 to 30 minutes and VAS axial pain increased from 2-3 to 4-5 independently, classification as remission decreased from 42% to 12% and from 28-33% to 5-11%, respectively. However, when VAS fatigue increased, it impacted less remission.

In priority ratings, 4 items were selected as important by 68-75% of rheumatologists: morning stiffness and axial pain (both included in the vignettes), as well as extra-articular manifestations and NSAID use, whereas only 18% selected fatigue. BASDAI was cited as the 1st priority criteria by 24% of rheumatologists and ASDAS as the 2nd by 16% of rheumatologists.

Figure 1. Frequencies of the declared remission states by rheumatologists for each of the 36 vignette cases

Conclusion: Morning stiffness, axial pain, NSAIDs use, and extra-articular manifestations seem to impact the physicians' perception of remission in axSpA, whereas fatigue has less impact on remission for rheumatologists. Consensus is needed on remission in axSpA.

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POS0244

PATIENT JOURNEY WITH AXIAL SPONDYLOARTHRITIS: CRITICAL ISSUES FROM THE PATIENT PERSPECTIVE. RESULTS FROM THE EUROPEAN MAP OF AXIAL SPONDYLOARTHRITIS (EMAS)

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Background: The journey of axial spondyloarthritis (axSpA) for most patients is slow and arduous.

Objectives: The goal of this analysis is to describe the journey to diagnosis and further management in axSpA patients.

Methods: 2,846 unselected patients participated in EMAS, a cross-sectional study (2017-2018) across 13 European countries. Descriptive analysis of socio-demographic factors, insurance scheme, diagnostic journey and post diagnosis healthcare utilization was performed. Mann-Whitney test was used to analyse possible differences between BASDAI (>4 v ≤ 4) and the number of visits to healthcare professionals and follow-up tests undertaken.

Results: Mean age was 43.9 years, 61.3% were female, 48.1% university educated, 67.9% married, 53.9% employed and 81.7% had public health insurance. Mean age at symptoms onset was 26.6 (11.1), while mean age at diagnosis was 33.7 (11.5) and mean diagnostic delay was 7.4 years. Over 50% had a diagnostic delay of ≥ 4 years. Prior to receiving a diagnosis, patients visited on average 2.6 specialists. The most commonly performed diagnostic tests were x-rays (72.3%), HLA B27 tests (65.4%) and MRIs (64.3%). 78.4% were diagnosed by a rheumatologist while 14.9% received their diagnosis by a GP. Patients who experienced a diagnostic delay of more than a year ($n=2,208$) undertook a considerable number of visits to specialists and medical tests in the year prior to participating in EMAS, which increased with disease activity. Patients with active disease (BASDAI >4) reported a higher number of visits to rheumatologists (3.7 ± 3.5 vs 2.9 ± 2.6), general practitioners (6.6 ± 10.0 vs 3.5 ± 4.1), physiotherapists (19.3 ± 25.0 vs 11.7 ± 17.0), and psychologists/psychiatrists (3.4 ± 10.7 vs 1.9 ± 7.7). Patients with active disease also undertook more x-rays (1.8 ± 2.8 vs 1.3 ± 1.9), MRI scans (0.9 ± 1.2 vs 0.6 ± 1.1), and blood tests (4.7 ± 4.4 vs 3.6 ± 3.2). However, one in five patients visited the rheumatologist only once in the year prior to EMAS (21.1%).

Conclusion: Diagnostic delay continues to be a key challenge in the axSpA patient journey, with patients waiting an average of 7.4 years and visiting multiple doctors prior to diagnosis. Once diagnosed, disease management presents a further challenge, as patients with higher disease activity reported more healthcare professional visits as well as medical tests. Safeguarding health and controlling healthcare utilization requires effective disease management, greater education for non-specialists, rapid referral routes for diagnosis and collaborative care between specialists and non-specialists.

Figure 1. axSpA Patient journey according to EMAS

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POS0245

PERFORMANCE OF STANDARDIZED SCORES FOR DISEASE ASSESSMENT AND PAIN IN PATIENTS WITH SPONDYLOARTHRITIS AND FIBROMYALGIA

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Background: The pathogenesis of spondyloarthritis (SpA) including axial SpA (axSpA) and psoriatic arthritis (PsA) differs from fibromyalgia (FM). However, symptoms partially overlap and both patient groups suffer from pain and stiffness. In addition, SpA patients may also develop a secondary form of FM. Classification criteria for SpA and diagnostic criteria for FM are used to differentiate between these subsets. Patient reported outcomes (PRO) often generated by questionnaires are used to assess severity and other disease features.

Objectives: To study whether PROs developed for axSpA, PsA, and related physician-based information behave in a similar way in patients diagnosed with FM without an additional chronic inflammatory rheumatic disease (CIRD) as in patients with a primary diagnosis of SpA without or with secondary FM.

Methods: Patients were consecutively recruited. The main inclusion criterion was a clinical diagnosis of FM (without CIRD), axSpA or PsA (without or with secondary FM) and the indication for a treatment adaptation (escalation or change within the same class) for any reason, based on the judgement of experienced rheumatologists. Standardized assessment tools and lab parameters (BASDAI, ASDAS-CRP, DAPSA, patient's and global assessment (NRS), CRP, BASFI, Fibromyalgia Impact questionnaire (FIQ), Leeds Enthesitis Index (LEI), Maastricht Ankylosing Spondylitis (MASES) and SpA Research Consortium of Canada (SPARCC) Enthesitis Score were assessed and compared between subgroups.

Results: The baseline demographics of 300 recruited patients (100 FM, 100 axSpA and 100 PsA) are shown in Table 1. All patients with FM (primary or secondary to SpA) showed the highest scores in almost all assessments, and this was independent of the main diagnosis (Table 2). In comparison, patients with axSpA or PsA without secondary FM showed significantly lower scores in all PROs as compared to those with primary and secondary FM, with exception of (i) scores of ASDAS-CRP and (ii) duration of morning stiffness (Question 6 of BASDAI), which were not affected by the presence of secondary FM (Table 2).

Conclusion: Secondary FM is leading to significantly higher levels of SpA-specific scores. ASDAS-CRP was the only score that was not influenced by the presence of secondary FM in patients with axSpA even though it was also increased in patients with primary FM, while similar results were found for the duration but not the level of morning stiffness. On the other hand, FM-specific questionnaires also showed high scores in patients with axSpA and PsA with concomitant FM but not in those without.

Table 1. Baseline characteristics of all diagnosis subtypes and comparison (p-values) to primary FM diagnosis. '+': diagnosis with concomitant FM, '-': diagnosis without concomitant FM

Table 1	FM	axSpA-	p-value	axSpA+	p-value	PsA-	p-value	PsA+	p-value
Age	56.4±10.2	53.5±14.2	0.086	48.7±13.5	0.026	56.0±13.2	<0.001	58.5±10.4	0.962
Male	2%	67%	<0.001	0%	---	38%	<0.001	6%	0.322
HLAB27 pos.	0%	84%	---	71%	---	16%	---	50%	---
CRP (mg/dl)	0.3±0.5	1.1±2.1	0.001	0.5±0.3	0.035	1.4±3.0	0.001	0.5±0.5	0.031
NRS pain	7.5±1.6	6.1±2.4	<0.001	7.7±1.8	0.768	6.4±2.2	<0.001	7.3±1.1	0.223

Table 2. Mean values (±standard deviation) of the assessed disease-specific indices and comparison (p-values) to primary FM diagnosis.

Table 2	FM	axSpA-	p-value	axSpA+	p-value	PsA-	p-value	PsA+	p-value
BASDAI	6.9±1.4	5.2±2.0	<0.001	6.9±1.4	0.858	---	---	---	---
BASDAI Q1: Fatigue	7.4±1.9	5.7±2.6	<0.001	7.8±1.2	0.667	---	---	---	---
ASDAS-CRP	3.3±0.6	3.1±1.0	0.086	3.7±1.2	0.208	---	---	---	---
BASFI	6.4±2.1	5.4±2.5	0.005	7.1±1.8	0.41	---	---	---	---
DAPSA	43.0±17.8	---	---	---	---	32.0±18.6	<0.001	46.5±19.7	0.37
FIQ	66.5±13.5	53.9±21.2	<0.001	72.3±13.7	0.352	57.2±18.3	<0.001	68.5±11.6	0.978
LEI	4.0±1.6	1.5±1.7	<0.001	3.3±1.4	0.179	2.4±2.0	<0.001	3.6±2.0	0.625
MASES	8.6±3.0	3.4±3.3	<0.001	8.2±2.9	0.642	4.2±3.8	<0.001	7.1±3.6	0.101
SPARCC	9.4±3.4	3.5±3.4	<0.001	7.7±3.8	0.139	5.1±3.7	<0.001	8.1±3.9	0.412

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Clinical vasculitis

POS0246

THE WORLDWIDE INCIDENCE AND PREVALENCE OF ANCA VASCULITIS: A SYSTEMATIC REVIEW AND META-ANALYSIS OF EPIDEMIOLOGICAL STUDIES

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