Table 1. Sensitivity, specificity, positive and negative predictive values, likelihood ratios of the DETAIL questionnaire both in our study and in the other study

DETAIL questionnaire													
Questions	Sensitivity (%)		Specificity (%)		Positive predictive value (%)		Negative predictive value (%)		Positive likelihood ratio		Negative likelihood ratio		
	Current study	Other study	Current study	Other study	Current study	Other study	Current study	Other study	Current study	Other study	Current study	Other study	
1. Have you ever had a finger or a toe and/or another joint swollen and painful for no apparent reason?	68.8	69.6	34.8	67.7	42.3	41	61.5	87.3	1.05	2.16	0.9	0.45	
2. Occasionally, has an entire finger or toe becomes swollen, making it look like a 'sausage'?	12.5	27.4	95.7	89.2	66.7	45.1	61.1	79.2	2.9	2.55	0.91	0.81	
3. Have you had pain in your heels?	43.6	45.1	56.5	86.3	41.2	51.6	59.1	82.9	1.01	3.3	0.99	0.64	
4. Have you ever had back pain lasting at least 3 months that was not injury related?	75	77.4	52.2	73.4	52.2	48.4	75	90.9	1.57	2.9	0.48	0.31	
5. Do you have low back pain in the morning and/or after resting that improves with exercise?	43.6	82.3	56.5	67.7	41.2	45.1	59.1	92.2	1.01	2.5	0.99	0.26	
6. Do you wake up at night because of low back pain?	18.8	54.9	78.3	85.4	37.5	54.9	58.1	85.4	0.87	3.7	1.04	0.53	

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.1231

POS0969

UNVEILING AXIAL INVOLVEMENT IN PSORIATIC ARTHRITIS: AN ANCILLARY ANALYSIS OF THE ASAS-PerSpA STUDY

D. Benavent¹, C. Plasencia¹, D. Poddubnyy², M. Kishimoto³, F. Proft², H. Sawada⁴, C. López-Medina^{5,6}, M. Dougados^{5,7}, V. Navarro-Compán¹.

¹Hospital Universitario la Paz-IdiPaz, Rheumatology Service, Madrid, Spain; ²Charité Universitätsmedizin Berlin, Department of Gastroenterology, Infectiology and Rheumatology, Berlin, Germany; ³Kyōrin University School of Medicine, Department of Nephrology and Rheumatology, Tokyo, Japan; ⁴Juntendo University School of Medicine, Department of Internal Medicine and Rheumatology, Tokyo, Japan; ⁵Hôpital Cochin. Assistance Publique- Hôpitaux de Paris, Rheumatology Department, Paris, France; ⁶Reina Sofia University Hospital, IMIBIC, University of Córdoba, Rheumatology Department, Córdoba, Spain; ⁷INSERM U1153, Clinical Epidemiology and Biostatistics, Paris, France

Background: Heterogeneity in psoriatic arthritis (PsA) is a current matter of discussion, especially concerning axial involvement.

Objectives: To determine the profile of axial PsA (axPsA) in a worldwide setting. Secondly, to identify predictive factors associated with the development of axial involvement in patients with PsA.

Methods: Data from 3684 patients with axial spondyloarthritis (axSpA) or PsA from the ASAS-PerSpA study were analysed. The ASAS-PerSpA is an observational, cross-sectional study that recruited consecutive patients with SpA from 68 centers worldwide. For this analysis, 367 PsA patients ever presenting axial involvement according to their rheumatologist were defined as axPsA and compared with 2651 axSpA patients, using logistic regression to later identify predictive factors for rheumatologist diagnosis of axPsA. In addition, the axPsA patients were also compared with 666 PsA patients without axial involvement (pPsA) and the characteristics associated with axial manifestations were determined by logistic regression analysis.

Results: Among all patients, 2651 were identified as axSpA and 1033 patients as PsA. Among those with axial involvement, 2651 were identified as axSpA (100% of axSpA) and 367 as axPsA (35.5 % of PsA). In comparison with axSpA, axPsA patients were less frequently males, older, less frequently HLA-B27 positive and had a higher body mass index (Table 1). Additionally, while patients with axPsA had more peripheral manifestations and psoriasis, concomitant IBD and uveitis were higher in axSpA. In the multivariable analysis, older age at diagnosis (OR= 1.04), peripheral arthritis (OR= 7.32) and dactylitis (OR= 2.82) were significantly associated with a diagnosis of axPsA. However, uveitis (OR= 0.22), IBD (OR= 0.12) or HLA-B27 carriage (OR= 0.26) were inversely associated with axPsA diagnosis as compared to axSpA. Furthermore, axial involvement in patients with PsA was significantly associated with male gender (OR= 1.68), elevated CRP (OR= 2.87), and the absence of psoriasis (OR= 0.33).

Conclusion: In this worldwide setting, axPsA was defined by rheumatologists as a unique phenotype, with disease features lying between axSpA and pure pPsA. Male gender, elevated CRP and the absence of psoriasis were associated with axial involvement in patients with PsA.

Table 1. Demographic and disease characteristics of patients with axial involvement included in the ASAS PerSpA study. Results shown as absolute numbers (percentages) or as the mean ± standard deviation

	axSpA n= 2651	axPsA n= 367	p-value
Sex (male)	1816 (68.5)	196 (53.4)	<0.001
Age at study visit	42.1 (13.0)	50.0 (12.7)	<0.001
Body Mass Index	25.9 (5.1)	27.4 (5.7)	<0.001
Family history of SpA	944 (35.6)	135 (36.8)	0.684
Past history or current symptoms of back pain	2625 (99.0)	358 (97.5)	0.04
Inflammatory back pain (ASAS definition), n/N(%)	2500/2632 (94.9)	317/362 (87.6)	<0.001
Sacroiliitis on imaging, n/N (%) by:			
xRay mNY criteria	1997/2586 (77.2)	185/298 (62.1)	<0.001
MRI-SIJ, ASAS definition	1449/1757 (82.4)	141/225 (62.6)	<0.001
mNY criteria or ASAS definition	2446/2634 (92.9)	243/339 (71.7)	<0.001
HLA B27 positive	1674 /2126 (78.7)	54/182 (29.6)	<0.001
Elevated CRP (>5 mg/dL)	1863/2569 (72.5)	274/356 (76.9)	0.2
Classification criteria			
ASAS criteria	2339 (88.2)	185 (50.4)	<0.001
CASPAR criteria	123 (4.6)	274 (74.4)	<0.001
Peripheral Arthritis	946 (35.7)	318 (86.6)	<0.001
Enthesitis	1086 (41.0)	198 (54.0)	<0.001
Dactylitis	155 (5.8)	125 (34.1)	<0.001
Psoriasis	185 (7.0)	324 (88.3)	<0.001
IBD	129 (4.9)	3 (0.8)	<0.001
Uveitis	576 (21.7)	13 (3.5)	<0.001
csDMARD (ever)	1359 (51.3)	339 (92.4)	<0.001
bDMARD (ever)	1585 (59.8)	263 (71.7)	<0.001
Specific drug for axial involvement			
NSAIDs	2465 (98.6)	317 (96.1)	0.002
csDMARD	828 (33.1)	187 (56.7)	<0.001
bDMARD	1288 (51.5)	180 (54.4)	0.32

axSpA: axial spondyloarthritis; axPsA: axial psoriatic arthritis; IBD: Inflammatory Bowel Disease; CRP: C-Reactive Protein; mNY: modified New York; csDMARDs: conventional synthetic DMARDs; bDMARDs: biological DMARDs; NSAID: Non-steroidal anti-inflammatory drugs

Disclosure of Interests: Diego Benavent: None declared, Chamada Plasencia: None declared, Denis Poddubnyy: None declared, Mitsumasa Kishimoto Consultant of: AbbVie, Amgen-Astellas BioPharma, Asahi-Kasei Pharma, Astellas, Ayumi Pharma, BMS, Chugai, Daiichi-Sankyo, Eisai, Eli Lilly, Gilead, Janssen, Kyowa Kirin, Novartis, Ono Pharma, Pfizer, Tanabe-Mitsubishi, Teijin Pharma, and UCB Pharma., Fabian Proft Grant/research support from: AbbVie, AMGEN, BMS, Celgene, MSD, Novartis, Pfizer, Roche, UCB, Haruki Sawada: None

declared, Clementina López-Medina: None declared, Maxime Dougados: None declared, Victoria Navarro-Compán: None declared.

DOI: 10.1136/annrheumdis-2021-eular.1410

POS0970

ASSESSMENT OF THE ASSOCIATION BETWEEN ESTIMATED CARDIOVASCULAR RISK AND MASEI INDEX IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

I. C. Aranda-Valera^{1,2,3}, I. Gómez García^{1,2,3}, M. L. Ladehesa Pineda^{1,2,3}, M. C. Ábalos-Aguilera^{1,2,3}, C. López-Medina^{1,2,3}, E. Collantes Estevez^{1,2,3}. ¹Reina Sofía Hospital, Rheumatology Service, Córdoba, Spain; ²IMIBIC, Rheumatology Service, Córdoba, Spain; ³University of Córdoba, Rheumatology Service, Córdoba, Spain

Background: It has been shown that the cardiovascular risk (CV) in spondyloarthritis (SpA) patients is higher than that of the general population. Furthermore, an association has recently been described between structural damage at the axial level and an increase in estimated CV risk¹.

Objectives: To evaluate the association between the estimated cardiovascular risk (CV) and the presence of subclinical atherosclerosis with the MASEI index (Madrid Sonographic Enthesis Index) in patients with axial spondyloarthritis (Ax-SpA) as an expression of peripheral enthesitis.

Methods: Cross-sectional study performed in 103 patients with ax-SpA from the Córdoba AxSpA Task force, Registry and Outcomes (CASTRO), in which patients undergoing treatment with biological therapy and with a previous history of CV event were excluded. Clinical data, disease activity data and factors related to CV risk were collected, as well as the presence of persistently elevated CRP levels in the five years prior to the study visit. The SCORE index was calculated, as well as the thickness of the carotid intima media (CIMT) and the MASEI index, both measured by ultrasound. The association between MASEI-SCORE and MASEI-atheroma plaques was evaluated using generalized linear models (GLM), adjusted for time of evolution of the disease, disease activity and smoking.

Results: Of the patients included, 35 were men (34.0%), with a mean age of 45.2 (±12.1) years and time of evolution of the disease of 18.5 (±13.0) years. The mean MASEI score was 13.6 (±9.1), and the mean SCORE score was 8.1 (±8.9). The GLM regressions showed that the MASEI was independently associated with the SCORE (coefficient β 0.22; 95% CI 0.02-0.43) adjusted for the duration of the disease, smoking, and the presence of persistent CRP (Table 1A). The MASEI index was also significantly associated with the CIMT, although these differences disappeared when the model was adjusted for other factors (Table 1B).

Table 1. A. Association between MASEI and SCORE adjusting for disease duration, smoking status and CRP.

	Crude model		Adjusted for disease duration		Adjusted for disease duration and smoking		Adjusted for disease duration, smoking and CRP	
	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value
MASEI	0.37 (0.20-0.55)	<0.001	0.25 (0.08-0.42)	0.006	0.25 (0.09-0.42)	0.004	0.22 (0.02-0.43)	0.039

Conclusion: In patients with ax-SpA, peripheral enthetic damage measured by the MASEI index is associated with an increase in estimated CV risk independently of the time of evolution, smoking and levels of CRP.

REFERENCES:

- Ladehesa-Pineda ML, Arias-de la Rosa I, López-Medina C, et al. Assessment of the relationship between estimated cardiovascular risk and structural damage in patients with axial spondyloarthritis. *Ther Adv Musculoskelet Dis* 2020;12:1-15

Table 1. B. Association between MASEI and intima media thickness (IMT) adjusting for disease duration, smoking status and CRP.

	Crude model		Adjusted for disease duration		Adjusted for disease duration and smoking		Adjusted for disease duration, smoking and CRP	
	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value	β coefficient (95%CI)	p-value
MASEI	0.01 (0.00-0.01)	0.041	0.003 (-0.01-0.004)	0.178	0.002 (-0.001-0.004)	0.149	0.002 (-0.001-0.005)	0.226

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.1525

POS0971

HOW DO CLINICAL AND SOCIOECONOMIC FACTORS IMPACT ON WORK DISABILITY IN EARLY AXIAL SPONDYLOARTHRITIS? FIVE-YEAR DATA FROM THE DESIR COHORT

E. Nikiphorou^{1,2}, A. Boonen^{3,4}, B. Fautrel⁵, P. Richette⁶, R. B. M. Landewe^{7,8}, D. Van der Heijde⁹, S. Ramiro^{7,9}. ¹King's College London, Centre for Rheumatic Diseases, London, United Kingdom; ²King's College Hospital NHS Trust, Rheumatology, London, United Kingdom; ³Maastricht University Medical Center and Care and Public Health Research Institute (CAPHRI), Rheumatology, Maastricht, Netherlands; ⁴Academic Hospital Maastricht, Internal Medicine, Division of Rheumatology, Maastricht, Netherlands; ⁵Sorbonne University – Assistance Publique Hôpitaux de Paris, Pitié Salpêtrière Hospital, Pierre Louis Institute for Epidemiology and Public Health, INSERM UMRS 1136, PEPITES Teams, Rheumatology, Paris, France; ⁶Université de Paris, Hôpital Lariboisière, Rheumatology, Paris, France; ⁷Zuyderland MC, Rheumatology, Heerlen, Netherlands; ⁸Amsterdam University Medical Center, Rheumatology, Amsterdam, Netherlands; ⁹Leiden University Medical Center (LUMC), Rheumatology, Leiden, Netherlands

Background: There remains substantial unmet need to study work disability (WD) in early axSpA. Previous studies suggest that treatment interventions alone do not improve work outcomes and that socioeconomic (SE) as well as clinical factors may play an important role.

Objectives: To investigate the occurrence of WD and the impact of clinical and SE factors on WD in early axial spondyloarthritis (axSpA).

Methods: Patients with a clinical diagnosis of axSpA from the DESIR cohort up to 5 years of follow-up (6-month visits in the first 2 years, followed by annual visits) were studied. Time to WD and potential baseline and time-varying predictors were explored, with a focus on SE variables: age, gender, smoking status since last visit, ethnicity (Caucasian vs other), job type based on 'collar' (blue vs white), educational status (low vs high -university), marital status (married vs not) and parental status (number of children); and clinical factors: disease activity (ASDAS/BASDAI), function (BASFI), mobility (BASMI), at each time point. The incidence of WD was calculated as the number of WD events over the total number of person-days under observation. Univariable analyses, followed by collinearity and interaction tests, guided subsequent multivariable Cox survival analyses.

Results: A total of 704 axSpA patients with work-related data, mean (SD) age 33.8 (8.6), were studied. The estimated incidence of WD amongst those at risk and across the five years of DESIR, was 0.05 (95% CI 0.03, 0.06) per 1000 days (total person-days of observation of 999,999). Mean (SD) time to WD was 976 days (SD 476), (min 163, max 2021 days). In people who developed WD, 25% did so at 595 days; 50% and 75% at 1050 and 1433 days, respectively. Significant differences in age, level of education, marital and parental status as well as disease activity, function and mobility, all at baseline, were seen between those developing WD vs those who never did. In multivariable models (Table 1), older age, higher ASDAS and BASFI all strongly predicted more WD ($p < 0.005$). In separate models adjusted for age, gender and education, BASFI and BASMI both predicted WD. SE factors, including education attained, were not associated with a risk for WD. There were no relevant interactions between clinical variables and SE factors.

Table 1. Univariable and multivariable model analyses with WD as outcome.

Type of analysis	Univariable	Multivariable model Focus on ASDAS	Multivariable model Focus on BASFI/ BASMI
	HR (95% CI)	HR (95% CI) (N=653)	HR (95% CI) (N=639)
Explanatory variables			
Age	1.07 (1.04, 1.11)	1.06 (1.02, 1.10)	1.03 (0.99, 1.08)
Male gender	0.68 (0.37, 1.23)	1.10 (0.58, 2.08)	1.00 (0.50, 2.02)
High education	0.25 (0.14, 0.48)	0.57 (0.29, 1.11)	0.42 (0.19, 0.90)
Parental status	1.36 (1.09, 1.70)	NS	NS
ASDAS (CRP)	2.40 (1.77, 3.26)	1.79 (1.27, 2.54)	Not tested
BASFI, 0-10	1.54 (1.36, 1.75)	1.42 (1.22, 1.65)	1.53 (1.29, 1.81)
BASMI, 0-10	2.13 (1.65, 2.75)	NS	1.49 (1.10, 2.00)
Symptom duration	0.79 (0.56, 1.12)	NS	NS
HLA B27 positive	0.64 (0.36, 1.13)	NS	NS
Hip involvement (baseline) vs not	1.98 (1.02, 3.82)	NS	NS
Comorbidity count	2.33 (1.68, 3.21)	NS	NS
NSAID use last 6m (vs no use)	1.01 (1.00, 1.02)	NS	NS
Oral Corticosteroid use (vs no)	2.72 (1.27, 5.83)	NS	NS
csDMARD use last 6m (vs no)	2.20 (0.90, 5.41)	NS	NS
TNFi use	2.15 (1.19, 3.87)	NS	NS

NS=Not significant

Conclusion: In this early axSpA cohort, WD was an infrequent event. Nevertheless, clinical factors are amongst the strongest predictors of WD, over SE factors,