Conclusion: Barriers more than facilitators of contextual factors are present in pts. with axSpA. This study shows that barriers in contextual factors are more common in pts. with impairments in self-reported and performed functioning as in those without impairments. This underlines the importance of contextual factors in the management of axSpA pts.

REFERENCES:

- [1] Kiltz et al. Ann Rheum Dis 2013;72(s3):572

Table 1. Presence of contextual factors, stratified for global functioning categories

ICF category	EFIS Item	Global Functioning (ASAS HI 0-17)		
		Good ≤ 5 (n= 69)	Moderate <5 to <12 (n= 106)	Poor ≥ 12 (n= 25)
e3	EFIS 1: As a result of my rheumatic disease, the children take more responsibility for household tasks.	11 (15,9)	55 (51,9)	21 (84)
e3	EFIS 2: I don't like the way my friends acts around me.	0 (0)	15 (14,2)	12 (48,0)
e3	EFIS 3: I can't count on my relatives to help me with my problems	11 (15,9)	24 (22,6)	9 (36)
e1	EFIS 4: I modify my home and work environments.	16 (23,2)	47 (44,3)	9 (36)
e5	EFIS 5: I have difficulties getting worsening of my disease acknowledged by a health care professional	3 (4,3)	21 (19,8)	16 (64)
e5	EFIS 6: Treatment of my rheumatic disease is taking up time	22 (31,9)	73 (68,9)	22 (88)
e4, e4	EFIS 7: My friends expect too much of me at home	1 (1,4)	18 (17,0)	7 (28)
e4, e4	EFIS 8: No one pays much attention to me at home	10 (14,5)	20 (18,9)	7 (28)
e4	EFIS 9: My friends understand me	56 (17,4)	83 (78,3)	12 (48)

values given as number (%)

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.1776

POS0974

IMPROVEMENT IN THE DIAGNOSTIC DELAY OF AXIAL SPONDYLOARTHRITIS, RESULTS FROM REAL WORLD DATA

J. Feld^{1,2}, O. Elkayam^{3,4}, A. Druyan^{4,5}, T. Reitblat⁶, A. Balbir-Gurman^{2,7}, A. Hada¹, T. Gazit¹, M. Elias¹, V. Fure³, T. Mashich⁷, D. Zisman^{1,2}, ¹Carmel Medical Center, Rheumatology, Haifa, Israel; ²Technion - Israel Institute of Technology, Medicine, Haifa, Israel; ³ביבא לת בוליקייה סילוח תיב, Rheumatology, Tel Aviv-Yafo, Israel; ⁴רלקאס ש"ע ביבא לת תטיסרבינוג האופרל הטוקופה, Rheumatology, Ramat Gan, Israel; ⁵Sheba Medical Center, Rheumatology, Ramat Gan, Israel; ⁶Barzilai Medical Center, Rheumatology, Ashkelon, Israel; ⁷Rambam Health Care Campus, Rheumatology, Haifa, Israel

Background: Diagnostic delay is a major challenge in axial spondyloarthritis (axSpA) with an extended interval of 8-10 years in Europe and 14 years in the United States between symptom onset and disease diagnosis (1, 2).

Objectives: To assess the delay in the diagnosis of axSpA over time in a real world axSpA cohort diagnosed in the last 3 decades and to evaluate factors associated with this delay.

Methods: A cohort of axSpA patients was recruited from a national multicenter registry of inflammatory arthritis. This cohorts' demographic, clinical and diagnostic variables were studied. The diagnostic delay was defined as the time interval between the year of first symptom and year of diagnosis. The mean and median diagnostic delay were calculated. A survival analysis was performed evaluating the association between the demographic, clinical and diagnostic variables on the diagnostic delay.

Results: Of the 373 axSpA patients in the registry, 198 (47%) are men. Ankylosing spondylitis fulfilling New York criteria was diagnosed in 73% of the patients. HLA-B*27 positivity was found in 64% of patients. The majority of the patients (63%) reported symptom onset between the age of 21-45, 21% before the age of 21 and 16% after the age of 45. Nine percent were diagnosed before the age of 21, 28% between 21-30, 23% between 31-40, 21% between 41-50 and 18% after the age of 50. One hundred and ten patients were diagnosed before 2000, 133 between 2001-2009 and 130 between 2010-2020. The mean and median delay in diagnosis was 9.1, 6 (±8.4) years when diagnosed before 2000, 5, 4 (±4.1) years when diagnosed 2001-2009, and 2, 1 (±1.5) years when diagnosed 2010-2020, respectively (graph 1). The only variable which was found to be associated with a shorter delay was the interval between symptom onset and first rheumatology consult: HR of 5.86 (4.3-8, p<0.001) if the rheumatology visit was within the first year of symptoms, HR 3.5 (2.4-5, p<0.001) if assessed 2-3 years after symptom onset. Additionally, age <21 at symptom onset was associated with a shorter

delay (p=0.005). Sex, type of axSpA (radiographic vs. non radiographic axSpA), level of education, and HLA-B*27 positivity were not associated with a delay in diagnosis.

Conclusion: Delay in axSpA diagnosis has significantly improved in this real-world cohort during the last decade. The most significant factor associated with a faster diagnosis was the time of the first rheumatology consult relative to symptom onset. Increasing the awareness of disease manifestations and early referral to a rheumatology service can improve the diagnosis delay of axSpA.

REFERENCES:

- [1] Sorensen J, Hetland ML, all departments of rheumatology in D. Diagnostic delay in patients with rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis: results from the Danish nationwide DANBIO registry. Ann Rheum Dis. 2015;74(3):e12.
- [2] Deodhar A, Mittal M, Reilly P, Bao Y, Manthana S, Anderson J, et al. Ankylosing spondylitis diagnosis in US patients with back pain: identifying providers involved and factors associated with rheumatology referral delay. Clin Rheumatol. 2016;35(7):1769-76.

Graph 1. The improvement in the delay in diagnosis of axial spondyloarthritis over the last 3 decades

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2021-eular.1802

POS0975

CLINICAL CHARACTERISTICS OF NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS IN ASIAN COUNTRIES COMPARED TO OTHER REGIONS: RESULTS OF THE INTERNATIONAL CROSS-SECTIONAL ASAS-COMOSPA STUDY

K. Ono¹, M. Kishimoto¹, S. Fukui², S. Kawai², G. A. Deshpande³, K. Yoshida⁴, N. Ichikawa⁵, Y. Kaneko⁶, T. Kawasaki⁷, K. Matsui⁸, M. Morita⁹, K. Tada¹⁰, N. Takizawa¹¹, N. Tamura¹⁰, A. Taniguchi⁵, Y. Taniguchi¹², S. Tsuji¹³, S. Kobayashi¹⁴, M. Okada², C. López-Medina¹⁵, A. Moltó¹⁵, D. Van der Heijde¹⁶, M. Dougados¹⁵, Y. Komagata¹, T. Tomita¹⁷, S. Kaname¹. ¹Kyorin University School of Medicine, Department of Nephrology and Rheumatology, Tokyo, Japan; ²St. Luke's International Hospital, St Luke's International University, Immuno-Rheumatology Center, Tokyo, Japan; ³Juntendo University School of Medicine, Department of General Internal Medicine, Tokyo, Japan; ⁴Brigham and Women's Hospital and Harvard Medical School, Division of Rheumatology, Inflammation, and Immunity, Department of Medicine, Boston, Massachusetts, United States of America; ⁵Tokyo Women's Medical University, Institute of Rheumatology, Tokyo, Japan; ⁶Keio University School of Medicine, Division of Rheumatology, Department of Internal Medicine, Tokyo, Japan; ⁷Shiga University of Medical Science, Department of Orthopedic Surgery, Shiga, Japan; ⁸Teine Keijinkai Hospital, Department of Rheumatology, Hokkaido, Japan; ⁹Fujita Health University, Department of Orthopaedic Surgery, Aichi, Japan; ¹⁰Juntendo University School of Medicine, Department of Internal Medicine and Rheumatology, Tokyo, Japan; ¹¹Chubu Rosai Hospital, Department of Rheumatology, Aichi, Japan; ¹²Kochi Medical School, Department of Endocrinology, Metabolism and Nephrology, Kochi, Japan; ¹³National Hospital Organization Osaka Minami Medical Center, Department of Orthopedics and Rheumatology, Osaka, Japan; ¹⁴Juntendo University Koshigaya Hospital, Department of Internal Medicine, Saitama, Japan; ¹⁵University of Paris, Cochin Hospital, Department of Rheumatology, Paris, France; ¹⁶Leiden University Medical Center, Department of Rheumatology, Leiden, Netherlands; ¹⁷Osaka University Graduate School of Medicine, Department of Orthopaedic Biomaterial Science, Osaka, Japan