Conclusion: In our cohort, 5.78% of the patients < 45 years with chronic low back pain had axial SpA (AS: 2.76%; and nr-axSpA: 3.02%). Approximately, one in every five patients had undiagnosed axial SpA. *Original manuscript made in collaboration with Novartis Argentina S.A*

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POS0985

DISEASE CONTROL PERCEPTION BY PHYSICIANS AND PATIENTS WITH ANKYLOSING SPONDYLITIS AND PSORIATIC ARTHRITIS IN REAL CLINICAL PRACTICE IN SPAIN: MIDAS STUDY RESULTS

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Background: There are few published data regarding physician' and patient' perception of the disease control for ankylosing spondylitis (AS) and psoriatic arthritis (PsA).

Objectives: To evaluate the relationship between physician' and patient' disease control perception compared to clinical outcomes for controlled disease (BASDAI<4 in AS or DAPSA≤14 in PsA).

Methods: MIDAS is an observational, non-interventional, cross-sectional, multicenter study. Patients ≥18 years with ≥6 months AS or PsA diagnosis according to ASAS and modified New York criteria or CASPAR criteria, respectively, undergoing treatment ≥3 months before inclusion. The endpoint of this analysis was the relationship between disease control perception by physicians and patients and disease control (BASDAI<4 in AS or DAPSA≤14 in PsA).

Results: 313 AS patients included: 75.7% male, 78.5% HLA-B*27+, a mean (SD) age of 50.4 (12.0) years, a mean (SD) disease duration of 15.5 (11.6) years and a mean (SD) CRP of 5.1 (8.2) mg/l. 313 PsA patients included: 54.3% male, 17.95% HLA-B*27+, a mean (SD) age of 54.1 (12.2) years, a mean (SD) disease duration of 10.5 (9.0) years and a mean (SD) CRP of 4.91 (7.3) mg/l. AS group: in 95.5% of AS patients with BASDAI<4, physician's perception matched the clinical evaluation, while only 42.3% of the patients with BASDAI≥4 matched physician's perception. Positive Predictive Value (PPV) was 75.1%, Negative Predictive Value (NPV) was 83.9% and precision was 76.7%. Patients perceived their own disease as controlled in 95.0% of cases with BASDAI scores <4 and as not controlled in 29.7% of cases with BASDAI score ≥4. PPV was 71.1%, NPV was 76.7% and precision was 71.9%. The same trend was observed when assessing disease control through ASDAS-CRP index. PsA group: in 96.2% of patients with DAPSA≤14, physician's perception matched the clinical evaluation, while only 47.6% of patients with DAPSA>14 matched the physician's perception. PPV was 73.1%, NPV was 89.6% and precision was 76.4%. Patients perceived their own disease as controlled in 93.5% of the cases with DAPSA scores ≤14 and as not controlled in 32.3% of the cases with DAPSA>14. PPV was 66.8%, NPV was 77.4% and precision was 68.4%. The same trend was observed when assessing disease control through the MDA criteria (Table 1).

Table 1. Physician's and patient's perception of the disease control related to disease control variables in AS and PsA

		Controlled disease by physician's perception?		Controlled disease by patient's perception?	
		Valid N	Yes N (%)	Valid N	Yes N (%)
AS	Disease control (BASDAI)	Controlled (BASDAI<4)	202 (100%)	193 (95.5%)	9 (4.5%)
		Not controlled (BASDAI≥4)	111 (100%)	64 (57.7%)	47 (42.3%)
	Disease activity (ASDAS-CRP)	Inactive (ASDAS-CRP<1.3)	92 (100%)	90 (97.8%)	2 (2.2%)
		Active (ASDAS-CRP≥1.3)	221 (100%)	167 (75.6%)	54 (24.4%)
PsA	Disease control (DAPSA)	Controlled (DAPSA≤14)	186 (100%)	179 (96.2%)	7 (3.8%)
		Not controlled (DAPSA>14)	126 (100%)	66 (52.4%)	60 (47.6%)
	Active disease (MDA)	Inactive (MDA criteria ≥5)	161 (100%)	154 (95.7%)	7 (4.3%)
		Active (MDA criteria <5)	151 (100%)	91 (60.3%)	60 (39.7%)

AS, ankylosing spondylitis; ASDAS-CRP, Ankylosing Spondylitis Disease Activity Score-C-reactive protein; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; DAPSA, Disease Activity in Psoriatic Arthritis; MDA, Minimal Disease Activity; PsA, psoriatic arthritis.

Conclusion: A higher agreement between physician's and patient' perception with the current clinical evaluation was observed when patients were controlled. MIDAS study showed that in real clinical practice in Spain, physicians perceived more disease control than the patients

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POS0986

GENDER DIFFERENCES IN DISEASE CONTROL AND HEALTH STATUS IN PATIENTS WITH ANKYLOSING SPONDYLITIS IN CLINICAL PRACTICE IN SPAIN: RESULTS OF THE MIDAS STUDY

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Background: Data on disease activity status and health status (HS) in clinical practice in Spain for patients with ankylosing spondylitis (AS) are scarce. The MIDAS study assessed the disease activity and the relationship with the reported HS in patients with AS treated in clinical practice in Spain.

Objectives: This is a sub-analysis to evaluate the differences in disease activity and HS by gender of the patients with AS included in the MIDAS study.

Methods: MIDAS is an observational, non-interventional, cross-sectional, multicenter study. Patients included were ≥ 18 years old with ≥ 6 months since diagnosis, were classified by ASAS and modified New York criteria; undergoing treatment ≥ 3 months. The primary variable was the disease control assessed by the percentage of patients in remission and low disease activity (measured by BASDAI and ASDAS-CRP)^{1,2}.

Results: We analyzed 313 AS patients; 237 (75.7%) were male and 76 (24.3%) female (Table 1). Disease control: According to BASDAI < 4 (total 64.5% (mean (SD) 3.1 (2.2)); 69.2% (2.9 (2.1)) of the males vs 50.0% (3.8 (2.4)) of the females had a BASDAI < 4 (Figure 1A). According to ASDAS-CRP, 57.5% of the AS patients showed low disease activity (ASDAS-ID + ASDAS-LDA), with a mean (SD) ASDAS-CRP of 1.9 (1.1); 138 (58.2%) males and 42 (55.3%) females showed low disease activity (Figure 1B). HS impact was low, with a mean (SD) ASAS-HI of 5.8 (4.4) for AS patients, that was 5.5 (4.4) for males and 6.8 (4.2) for females.

Table 1. Baseline demographic and clinical characteristics of the AS patients analysed.

	Total (n=313)	Male (n=237)	Female (n=76)
Age (years), mean (SD)	50.4 (12.0)	50.1 (12.2)	51.2 (11.5)
Years since diagnosis, mean (SD)	15.5 (11.6)	16.8 (12.2)	11.4 (8.5)
Years since the symptoms' onset to the study visit, mean (SD)	20.5 (12.7)	22.2 (13.0)	15.2 (9.9)
Years since the symptoms' onset to diagnosis, mean (SD)	5.0 (7.2)	5.4 (7.7)	3.9 (5.6)
BMI (kg/m ²), mean (SD)	27.0 (4.9)	27.5 (4.6)	25.5 (5.6)
Obesity (BMI >30), n (%)	67 (23.0%)	53 (23.7%)	14 (20.9%)
Smoking habit			
Current smoker, n (%)	75 (24.0%)	61 (25.7%)	14 (18.4%)
Ex-smoker (>6 months), n (%)	81 (25.9%)	68 (28.7%)	13 (17.1%)
Non-smoker, n (%)	137 (43.8%)	96 (40.5%)	41 (53.9%)
Family history of AS, n (%)	66 (21.1%)	48 (20.3%)	18 (23.7%)
Presence of HLA-B27, n (%)	245 (78.5%)	187 (79.2%)	58 (76.3%)
Patients previously treated with bDMARD	99 (31.6%)	77 (32.5%)	22 (28.9%)
Active disease, n (%) [*]			
BASDAI ≥ 4	111 (35.5%)	73 (30.8%)	38 (50.0%)
ASDAS-CRP ≥ 2.1	133 (42.4%)	99 (41.8%)	34 (44.7%)
CRP levels (mg/l), mean (SD)	5.1 (8.2)	5.7 (9.0)	3.3 (4.3)
PASS, n (%)	270 (86.3%)	208 (87.8%)	62 (81.6%)
ASAS-HI, mean (SD)	5.8 (4.4)	5.5 (4.4)	6.8 (4.2)

*Refers to the percentage of patients with active disease according to BASDAI ≥ 4 and ASDAS-CRP ≥ 2.1 . AS, ankylosing spondylitis; ASAS-HI, Assessment of Spondyloarthritis International Society - Health index; ASDAS, Ankylosing Spondylitis Disease Activity Score; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; bDMARD: biologic disease modifying anti-rheumatic drug; BMI, body mass index; CRP, C-reactive protein; HLA-B27, human leukocyte antigen B27; PASS, patient acceptable symptom state; SD, standard deviation.

Conclusion: Our analysis showed a higher proportion of females with active disease when using the BASDAI definition. However, when using the ASDAS-CRP definition, these differences by gender seem to be less pronounced. Also, the impact of disease activity on the HS seems to be higher in females than males. As far as we know, this is the first Spanish study to evaluate gender in this patient population.

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Figure 1. Disease status by sex A) Disease control according to BASDAI B) Disease status according to ASDAS-CRP

ASDAS-CRP, Ankylosing Spondylitis Disease Activity Score- C-reactive protein; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index.

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POS0987 INFLAMMATION OF THE HIP JOINTS IN EARLY AXIAL SPONDYLOARTHRITIS: DATA ANALYSIS OF VISUALIZATION METHODS

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Background: According to epidemiological studies in Russia, the inflammation of the hip joints occurs in half of patients with ankylosing spondylitis (AS). There have been practically no studies devoted to the investigations of coxitis in patients with early axial spondyloarthritis (axSpA). It is still unknown what factors cause the development of coxitis in axSpA; there is no generally accepted algorithm for diagnosing this condition, especially at an early stage. Previous studies have shown that coxitis in patients with AS develops on average 5–10 years after the onset of the disease, some patients already have irreversible changes in the hip joint at the time of diagnosis, and some do not develop coxitis never.

Objectives: To compare the clinical manifestations of coxitis with the results of magnetic resonance imaging (MRI), ultrasound (US), and radiography of the hip.

Methods: We examined 175 patients (mean age 28.0 ± 5.92 years) with axSpA (ASAS, 2009), with a duration of inflammatory back pain of no more than 5 years, from the CoRSaR cohort. The median duration of the disease was 21 [3–60] months. BASDAI - 4.0 ± 2.0 , BASFI - 2.0 [0.4; 3.5]. Among the included patients, 69 (39.4%) had nr-axSpA, and 106 - AS; 87% were HLA-B27 positive. All patients underwent US examination of the hip joint. When synovitis was detected, the patients underwent MRI examination of the hip joint. The increase in the cervical-capsular distance (CCD) more than 7 mm was considered as an ultrasonic coxitis. The median CCD was 7.5 [7.0; 8.2] mm. For coxitis in MRI, osteitis of the head of the hip or acetabulum and synovitis were taken. Radiographic severity of coxitis was determined by BASRI hip.

Results: According to the US data, synovitis of the hip joint was detected in 54 from 175 (30.9%) patients. Pain in the hip joint had 33 (61%) patients. There was no correlation between the intensity of pain and CCD. CCD significantly correlated with laboratory indicators of disease activity, such as ESR ($r = 0.34$; $p < 0.05$) and CRP ($r = 0.3$; $p < 0.05$). Only 7 (13.0%) patients had BASRI hip stages II or III and the rest had normal hip joints. 39 (72%) had MRI manifestations of coxitis: 36 (66%) patients had synovitis, 1 (2%) had bone marrow edema, and 2 (4%) had a combination of synovitis with osteitis. Patients with and without radiographic coxitis did not differ in terms of disease activity and functional indices.

Conclusion: In early axSpA:

- 30.9% of patients have hip synovitis, and among them, MRI signs of coxitis have 72%, and X-ray coxitis - 13%;
- ultrasound synovitis is only confirmed by MRI in 70% of cases;
- it seems that the radiological progression of coxitis does not depend on the activity of the disease.

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