POS1062 ULTRASOUND ASSESSMENT OF SUB-CLINICAL HAND JOINT SYNOVITIS: A COMPARATIVE STUDY BETWEEN PSORIATIC AND RHEUMATOID ARTHRITIS

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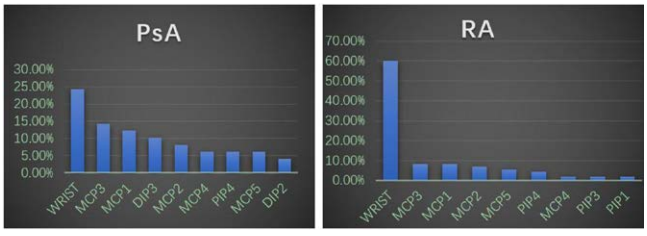
Background: Ultrasound (US) detected subclinical synovitis can be present in early psoriatic arthritis (PsA) and rheumatoid arthritis (RA), and also in patients fulfilling clinical remission criteria[1-2]. Numerous evidences support that the persistence of subclinical synovitis detected by US is associated with a high risk of disease progression [2-3].
Objectives: To evaluate sub-clinical synovitis of PsA and RA at the level of small joints of the hand and wrist by B-mode and Power Doppler US.
Methods: 21 patients of early PsA and 25 patients of early RA (no clinical evidence of hand joint involvement, PsA disease duration <2 years, and RA disease duration <1 year) were recruited. DAS28 and DAPSA score used for assessment of articular disease activity for RA and PsA, respectively. US [grey scale (GS) and power Doppler (PD)] was performed to assess synovitis of bilateral wrists, metacarpophalangeal joints, proximal and distal interphalangeal joints, altogether 30 joints. A GS score ≥2 and/or a PD score ≥1 were used to identify US detected synovitis.
Results: A total of 25 patients were included in the RA group, including 5 males and 20 females. A total of 21 patients were included in the PsA group, including 7 males and 14 females. There were no significant differences in gender composition, age, and duration of disease between the two groups (P>0.05) (Table 1). 14 (66.67%) PsA patients and 12 (48%) RA patients had sub-clinical hand joint synovitis. Among 630 hand joints scanned in PsA group, 49 (7.78%) joints showed evidence of sub-clinical synovitis. Wrist joint was most commonly involved (24.49%), followed by MCP3 (14.29%), MCP1 (12.24%) and DIP3 (10.20%). Among 750 hand joints scanned in RA group, 110 (14.67%) joints showed evidence of sub-clinical synovitis. Wrist joint was most commonly involved (60.00%), followed by MCP3 (8.24%), MCP1 (8.24%) and MCP2 (7.06%). No correlation noted between numbers of joints with subclinical synovitis with DAPSA and DAS28 score. There was no correlation between number of joints with sub-clinical synovitis and disease activity indices.
Conclusion: Almost two-thirds patients with PsA and half patients with RA had US evidence of sub-clinical synovitis in wrist and hand joints, most commonly in wrist. There are some similarities in the joint involvement of sub-clinical synovitis between RA and PsA, physicians should take this into account in clinical work.

Table 1. Demographic characteristics of RA and PsA patients

	RA (n=25)	PsA (n=21)	*P*
Female, n(%)	20 (80.00%)	14 (66.67%)	0.305
Age, years, mean±SD	56.32±12.18	54.31±15.82	0.637
Disease duration, years, mean±SD	1.06±0.59	0.90±0.58	0.363



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Acknowledgements: This work was supported by National Natural Science Foundation of China (No. 82071930 and 81571684).
Disclosure of Interests: None declared.
DOI: 10.1136/annrheumdis-2021-eular.838

POS1063 RHEUMATOLOGIST AND PATIENT PERSPECTIVES ON IMPLEMENTING CARDIOVASCULAR RISK PREVENTION IN THE MANAGEMENT OF PSORIASIS: A QUALITATIVE STUDY

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Background: Psoriatic arthritis (PsA) is an immune-mediated musculoskeletal disease associated with excess risk for cardiovascular disease (CVD). New US-based guidelines recognize psoriasis as a CVD risk enhancer; however, patients with PsA often do not have CVD risk factors identified nor managed.
Objectives: This study examines strategies to improve CVD prevention care from the perspective of rheumatologists and patients with PsA.
Methods: Semi-structured qualitative interviews were conducted using an interview guide based on the Consolidated Framework for Implementation Research to examine the perspectives of rheumatologists (N = 8) and patients with psoriatic arthritis managed by rheumatologists (N = 8) on barriers/facilitators to CVD prevention. Interviews were transcribed and coded using an integrated approach designed to enhance reliability and validity facilitated by NVivo software.
Results: Most rheumatologists confirmed that they were not regularly engaging in CVD prevention care with psoriatic arthritis patients. Providers reported sometimes counseling and screening for CVD risk, but they were not regularly prescribing statins and not as willing to do so. Reasons included a lack of familiarity or comfort with guidelines, concern about working outside of their scope of practice, confusing boundaries between other clinicians, and time constraints. Most patients confirmed that it was uncommon for their rheumatologists to engage them in CVD prevention care but expressed desire for their rheumatologists inform them of the risk, and were open to CVD prevention care from them.
Conclusion: We identified several potentially modifiable barriers to CVD screening and management. These findings will inform the design of a clinical trial comparing the effectiveness of rheumatologist implementation of CVD guideline-based counseling, screening and prescribing statins when appropriate in patients with PsA.

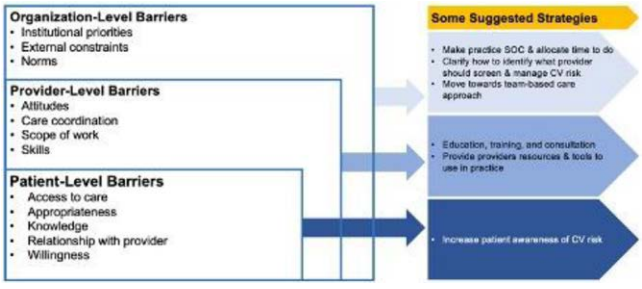

Figure 1. Barriers to CVD screening and management among patients with PsA in a rheumatology practice setting and potential strategies to address those barriers. Abbreviations: CV = cardiovascular; SOC = standard of care.

Disclosure of Interests: Alexis Ogdie Consultant of: Abbvie, Amgen, BMS, Celgene, Corrona, Gilead, Janssen, Lilly, Novartis, Pfizer, UCB, Grant/research support from: Pfizer to Penn, Novartis to Penn, Amgen to Forward/NDB, Alix Gustafson: None declared, Adina Lieberman: None declared, Jennifer Mason: None declared, April Armstrong: None declared, Nehal Mehta Consultant of: Amgen, Eli Lilly, and Leo Pharma receiving grants/other payments, Grant/research support from: AbbVie, Celgene, Janssen Pharmaceuticals, Inc, and Novartis receiving grants and/or research funding and as a principal investigator for the National Institute of Health receiving grants and/or research funding., Employee of: NNM is a full-time US government employee, Rinad Beidas Consultant of: Camden Coalition of Healthcare Providers in the past 3 years. She currently is a consultant for United Behavioral Health. She serves on the Optum Behavioral Health Clinical and Scientific Advisory Council. Dr. Beidas receives royalties from Oxford University Press., Joel Gelfand Shareholder of: Dr Gelfand is a co-patent holder of resiquimod for treatment of cutaneous T-cell lymphoma, and he is a deputy editor for the Journal of Investigative Dermatology, receiving honoraria from the Society for Investigative Dermatology., Paid instructor for: CME work related to psoriasis that was supported indirectly by Eli Lilly and Company and Ortho Dermatologics, Consultant of: Bristol-Myers Squibb, Boehringer Ingelheim, GlaxoSmithKline, Janssen Biologics, Novartis Corp, UCB (Data Safety and Monitoring Board), Sanofi, and Pfizer Inc, Grant/research support from: research grants (to the Trustees of the University of Pennsylvania) from AbbVie, Janssen, Novartis Corp, Celgene, OrthoDermatologics, and Pfizer Inc.
DOI: 10.1136/annrheumdis-2021-eular.902