higher prevalence of syndesmophytes (44% vs 36%, $p=0.06$) and hip involvement (20% vs 15%, $p=0.09$) was observed in the group of AU. Regarding CV risk features, no differences were observed in the prevalence of CV risk factors and events (Table 1). Patients with AU showed a higher cIMT in the crude analysis (665 ± 156 mm vs 640 ± 142 mm, $p=0.047$), but no significant differences were observed after adjustment by age and sex ($p=0.6$). Prevalence of carotid plaques was comparable in both groups (32% Vs 32%, $p=0.84$).

Table 1.

	axSpA without uveitis (n=709)	axSpA with uveitis (n=177)	p	P (adjusted model)
Men/Women, n	477/232	122/55	0.68	
Mean age (years) $\pm$ SD at the time of study	48 $\pm$ 13	50 $\pm$ 11	0.049	
AS/nr-AxSpA	541/168	160/17	0.000	
History of CV risk factors, n (%)				
Current smoker	247 (35)	50 (28)	0.096	
Obesity				
Dyslipidemia	233 (33)	63 (36)	0.48	
Hypertension	188 (27)	50 (28)	0.63	
Diabetes Mellitus	50 (7)	14 (8)	0.69	
Chronic Kidney Disease	18 (3)	4 (2)	0.99	
History of cardiovascular events, n (%)	29 (4)	12 (7)	0.13	
Structural damage at the time of study				
Presence of syndesmophytes, n (%)	253 (36)	77 (44)	0.063	
mSASSS	5 (1-15)	6 (0-16)	0.31	
Severe sacroiliitis (grade 3,4), n (%)	348 (49)	122 (69)	0.000	0.000*
Carotid US data at the time of study				
Carotid plaques, n (%)	225 (32)	57 (32)	0.84	
IMT (mm)	640 $\pm$ 142	665 $\pm$ 156	0.047	0.6**
IMT $\geq$ 0.900 mm	36 (5)	10 (6)	0.72	

*: adjusted by age, disease duration and AS/nr-axSpA ratio

**: adjusted by age and sex

Abbreviations: AS = ankylosing spondylitis. AxSpA= axial spondylitis. CV = cardiovascular. IMT = intima-media wall thickness. Nr-axSpA = no-radiographic axial spondylitis.

Conclusion: The presence of AU does not confer additional CV risk to axSpA patients, although it is associated with a more severe structural damage in our series.

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POS1391 MEASURING SUBCLINICAL INFLAMMATION IN HAND AND FOREFOOT IN PATIENTS WITH ARTHRALGIA USING 1.5T OR 3.0T MRI: DOES FIELD STRENGTH MATTER?

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Background: Magnetic resonance imaging (MRI) of small joints sensitively detects inflammation. MRI-detected subclinical inflammation, and tenosynovitis in particular, has been shown predictive for RA development in patients with arthralgia. These scientific data are mostly acquired on 1.0T-1.5T MRI scanners. However, 3.0T MRI is nowadays increasingly used in practice. Evidence on the comparability of these field strengths is scarce and it has never been studied in arthralgia where subclinical inflammation is subtle. Moreover, comparisons never included tenosynovitis, which is, of all imaging features, the strongest predictor for progression to RA.

Objectives: To determine if there is a difference between 1.5T and 3.0T MRI in detecting subclinical inflammation in arthralgia patients.

Methods: 2968 locations (joints, bones or tendon sheaths) in hands and forefeet of 28 arthralgia patients were imaged on both 1.5T and 3.0T MRI. Two independent readers scored for erosions, osteitis, synovitis (according to RAMRIS) and tenosynovitis (as described by Haavaardsholm et al.). Scores were also summed as total inflammation (osteitis, synovitis and tenosynovitis) and total RAMRIS (erosions, osteitis, synovitis and tenosynovitis) scores. Interreader reliability (comparing both readers) and field strength agreement (comparing 1.5T and 3.0T) was assessed with interclass correlation coefficients (ICCs). Next, field strength agreement was assessed after dichotomization into presence or absence of inflammation. Analyses were performed on patient- and location-level.

Results: ICCs between readers were excellent (>0.90). Comparing 1.5 and 3.0T revealed excellent ICCs of 0.90 (95% confidence interval 0.78-0.95) for the total inflammation score and 0.90 (0.78-0.95) for the total RAMRIS score. ICCs for individual inflammation features were: tenosynovitis: 0.87 (0.74-0.94), synovitis 0.65 (0.24-0.84) and osteitis 0.96 (0.91-0.98). The field strength agreement on dichotomized scores was 83% for the total inflammation score and 89% for the total RAMRIS score. Of the individual features, agreement for tenosynovitis was the highest (89%). Analyses on location- level showed similar results.

Conclusion: Agreement of subclinical inflammation scores on 1.5T and 3.0T were good to excellent, in particular for tenosynovitis. This suggests that scientific evidence on predictive power of MRI in arthralgia patients, obtained on 1.5T, can be generalized to 3.0T when this field strength would be used for diagnostic purposes in daily practice.

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POS1392 ECHOCARDIOGRAPHIC FINDINGS IN PSORIATIC ARTHRITIS, RHEUMATOID ARTHRITIS AND CONTROLS

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory arthropathy associated with cardiovascular abnormalities (1). The echocardiography is a non-invasive tool useful in the detection of cardiac abnormalities, which may be the only manifestation of cardiac involvement preceding a global dysfunction. However, echocardiographic differences between PsA patients, rheumatoid arthritis (RA) patients, and controls have not yet been well described.

Objectives: To analyze the echocardiographic parameters in PsA patients and to compare them with RA patients and controls.

Methods: This cross-sectional, observational and comparative study, included thirty-six patients (nineteen in each group), aged 40-75 years, with PsA and RA who fulfilled the CASPAR (Classification criteria for Psoriatic Arthritis) and ACR/EULAR 2010 classification criteria, respectively, matched by age, gender and comorbidities with nineteen healthy controls. Exclusion criteria were a poor echocardiographic window, patients with a previous atherosclerotic cardiovascular disease (ischemic heart disease, cerebrovascular accident or peripheral arterial disease), and pregnancy. Transthoracic echocardiogram was performed and reviewed by 2 board-certified cardiologists, in all study subjects. Comparisons were done with X2, Kruskal Wallis or ANOVA.

Results: There were not differences in the demographic characteristics between groups (Table 1). When comparing echocardiographic findings a statistically significant difference was found in the prevalence of diastolic dysfunction, being more prevalent in PsA and RA patients compared with controls (52.6% vs 52.6% vs 5.3%, $p=0.002$), likewise the presence of mild mitral valve regurgitation was higher (84.2% vs 53.6% vs 10.5%, $p=0.001$) and mild pulmonary valve regurgitation (68.4% vs 10.5% vs 0%, $p=0.001$). Prevalence of abnormal left ventricular geometry was higher in PsA and RA patients than controls (68.4% vs 63.2% vs 21.1%, $p=0.006$).

Table 1. Comparison of demographic characteristics and echocardiographic findings between patients with PsA, RA and controls.

	PsA (n=19)	RA (n=19)	Controls (n=19)	p
Age, years $\pm$ SD	54.7 $\pm$ 7.7	55.4 $\pm$ 9.9	55.3 $\pm$ 5.9	NS
Female, n (%)	11 (57.9)	11 (57.9)	11 (57.9)	NS
Diabetes Mellitus	4 (21.1)	3 (15.8)	2 (10.5)	NS
Hypertension	10 (52.6)	8 (42.1)	7 (36.8)	NS
Dyslipidemia	10 (52.6)	4 (21.1)	7 (36.8)	NS
Active smoking	4 (21.1)	2 (10.5)	5 (26.3)	NS
Disease duration, years (p25-p75)	6 (4-14)	7 (5-18)	-	NS
DAS28-CRP, mean $\pm$ SD	2.2 $\pm$ 0.8	3.1 $\pm$.8	-	0.003
Echocardiographic findings				
Diastolic dysfunction, n (%)	10 (52.6)	10 (52.6)	1 (5.3)	0.002
LV mass index, g/m ² (p25-p75)	78.9 (55.9-86.9)	73.7 (61.0-85.7)	69.5 (52.0-98.7)	NS
LVEF, $\pm$ mean SD	62.3 $\pm$ 6.1	59.7 $\pm$ 8.6	62.9 $\pm$ 6.1	NS
TAPSE, cm $\pm$ SD	21.8 $\pm$ 2.7	22.4 $\pm$ 2.7	23.7 $\pm$ 3.1	NS
Mild aortic regurgitation, n (%)	5 (26.3)	4 (21.1)	1 (5.3)	NS
Mild mitral regurgitation, n (%)	16 (84.2)	10 (52.6)	2 (10.5)	<0.001
Mild pulmonary regurgitation, n (%)	13 (68.4)	2 (10.5)	0 (0)	<0.001
Mild tricuspid regurgitation, n (%)	15 (83.3)	13 (76.5)	11 (57.9)	NS
LV geometry alterations, n (%)	13 (68.4)	12 (63.2)	4 (21.1)	0.006
Concentric remodeling, n (%)	12 (63.2)	10 (52.6)	4 (21.1)	0.025

NS, non-significant; DAS28-CRP, disease activity score using 28 joints and C reactive protein; LV, left ventricular; LVEF, left ventricular ejection fraction; TAPSE, tricuspid annular plane systolic excursion.