Conclusion: We show that rheumatologists in the TREASURE group prefer to initiate anti-TNF drugs first in all advanced CRD stages. Etanercept was the first choice in these patients.

REFERENCES:


Disclosure of Interests: None declared

AB0768 COMPARISON OF THE CLINICAL-LABORATORY REMISSION AND THE ASAS PARTIAL REMISSION IN PATIENTS WITH EARLY AXIAL SPONDYLOARTHRITIS

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Conclusion: The criteria for clinical-laboratory remission are comparable to the ASAS criteria for partial remission in patients with early axSpA and can be used in a practice of rheumatologists. Further research is needed to analyze the various criteria for axSpA and their applicability in a practice.

REFERENCES:


AB0768 INFLUENCE OF CONTINUOUS NON-STEROIDAL ANTI-INFLAMMATORY DRUGS INTAKE ON BONE MARROW EDEMA IN NON-RADIOGRAPHIC SPONDYLOARTHRITIS

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Background: The concept of non-radiographic axial spondyloarthritis (nr-axSpA) has revolutionized the classical understanding of axSpA. Indeed, it facilitated the classification of patients with axSpA who did not present substantial structural damage as it was only detectable on magnetic resonance imaging of the sacroiliac joints (MRI-SIJ) [1]. Continuous non-steroidal anti-inflammatory (NSAIDs) intake has been reported as a potential factor reducing the sensitivity of MRI-SIJ to detect bone marrow edema (BME).

Objectives: The aim of the study was to investigate the effect of continuous NSAIDs intake on BME in nr-axSpA.

Methods: We undertook a cross-sectional study including nr-SpA according to the ASAS criteria and treated with NSAIDs at baseline. Socio demographic data as well disease characteristics were recorded. Disease activity parameters were also collected including the duration of morning stiffness, night awakenings, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI). MRI-SIJ was performed for all the patients. All the images were screened for bone marrow edema with the corresponding sequence (short tau inversion). Patients were grouped according to NSAIDs intake: G1: continuous versus G2 occasional. The level of significance was fixed for p<0.05.

Results: The study included 43 nr-axSpA patients. There was a female predominance with a sex ratio of 2.1 [0.8]. The pre-scribed NSAIDs were as follows: Diclofenac (44 %), Indomethacin (8%), Ketoprofen (18%), Meloxicam (3%), Celecoxib (3%), Piroxicam (3%) and Naproxen (21%). Nearly half of the patients were continuously taking NSAIDs (52.6%) versus occasional intake (47.4%). Four patients failed two NSAIDs and were treated with a third one. Both groups were comparable for age (p=0.193), sex (p=0.386), and disease duration (p=0.4). Similary, there were no statistically significant differences regarding disease activity parameters between both groups: numerical rating scale of pain (p=0.713), ESR (p=0.314), CRP (p=0.644), morning stiffness (p=0.428), night awakening (p=1), as well as BASDAI (p=0.514). Regarding MRI-SIJ findings, hyper signal in STIR sequence was comparable between both groups (G1: 35% vs G2:33%, p=0.914). Moreover, the increased signal with Gadolinium injection on T₁-weighted images was similar between both groups (p=0.113).

Conclusion: Our study showed that continuous NSAIDs intake was not associated with significant changes in MRI-SIJ features. This study suggests that a NSAID-free period is not necessary before assessing bone marrow edema on MRI-SIJ.

REFERENCES:

graph 1. Comparison of the clinical-laboratory remission and the ASAS partial remission in patients with axSpA at 3 y of follow-up.

Graph 1. Comparison of the clinical-laboratory remission and the ASAS partial remission in patients with axSpA at 3 y of follow-up.