

**Methods:** This is a cross-sectional study involving patients with knee osteoarthritis. Sociodemographic and clinical data, including comorbidities, were collected. Neuropathic pain was assessed by the DN4 questionnaire. Neuropathic pain was defined by a DN4  $\geq 4$ . Depression, catastrophizing, and central sensitization were assessed by Arabic versions of validated questionnaires, PCS (Pain Catastrophizing Scale) for catastrophizing, and PHQ9 (Patient Health Questionnaire) for depression, CSI (central sensitization inventory) for central sensitization.

**Results:** 173 patients were included in our study. 88.2% are women. The average age was 58.0 $\pm$ 9.19 years. 32.7% had neuropathic pain. VAS mean pain was 4.4 $\pm$ 2.1. The median duration of evolution was 3.8 years [1-23]. The average lequesne index was 9.75 $\pm$ 3.9. The median of the PCS score was 22 [0 -52], and the median of the PHQ9 score was 7 [0 - 24]. The average CSI score was 38.2 $\pm$ 15. 72.6% of patients had comorbidities: 28.8% had obesity and 12.7% were diabetic. In multivariate analysis, only functional disability was associated with the presence of neuropathic pain  $p=0.04$  (OR: 1.19, 95% CI [1.03 - 1.38]). However, pain severity, central sensitization, comorbidities including diabetes and obesity did not come out as associated factors.

**Conclusion:** Neuropathic pain is quite common in gonarthrosis. Functional disability seems to be an associated factor.

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**Disclosure of Interests:** None Declared.

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### AB1197 CAN OSTEOARTHRITIS, SARCOPENIA AND BODY COMPOSITION PREDICT LOSS OF FUNCTION?

**Keywords:** Sarcopenia, Osteoarthritis

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**Background:** Elderly populations e growing in the majority of Countries in the World. Portugal in currently among the 5 most aged counties with 23.4% of it's population over 65 and an ageing index of 182[1]. Osteoarthritis is the 3<sup>rd</sup> cause of responsible for severe disability in adults over 60 years in developed and developing countries[2]. Lack of data at a national or regional level in Portugal compromises the ability to prepare for both health and care need of aged population. Simultaneously the region of Algarve has particular geographic characteristics with 49% of the population living within 2 km from the coast (in 9% of the Algarve's Territory).

**Objectives:** Are aim was to study our regional population, namely the incidence of Osteoarthritis (OA) and the relation of function ability with OA, Sarcopenia and Body composition.

**Methods:** This study is a prospective, observational secondary analysis of data from the "Sarcopenia Screening Study in the Algarve Region". Subject were recruited through informative flyers that was distributed at Elderly Associations, Senior Universities,... in different areas of the region of Algarve. Subsequently, by appointment, the evaluations were performed. Until June 2022 a total of 270 participants have voluntarily participated. Subjects over 60 were eligible for the study. All gave their informed consent to participate. Clinical diagnose of OA was established according to the NICE Guidelines for knee osteoarthritis diagnose[3]. Functional ability was measures with the Lower Extremity Functional Scale (LEFS)[4], sarcopenia was measures with the SARC-F Questionnaire[5], body composition was evaluated by Medical Body Composition SECA® mBCA515. Data was treated with IBM-SPSS-Statistics version 26.

**Results:** Of the 270 subjects analyzed for this secondary analyze 75,2% were female (24,8% male), mean age in years 75,39  $\pm$  6,75 (60-93). 70,5% had Knee OA. Statistical differences was found between groups (with and without OA), in LEFS ( $p<0,001$ ), SARC-F ( $p<0,001$ ), percentage of fat free mass ( $p<0,001$ ). A multiple linear regression was carried out to see if having OA, Sarcopenia and percentage of fat free mass can predict LEFS, once all were significantly different within groups, creating a statistically significant model  $Z(3,233)=155,957$ ;  $p<0,001$ ;  $R^2=0,668$ ] were with having OA ( $\beta=-0,121$ ;  $t=-271$ ;  $p=0,003$ ), Sarcopenia ( $\beta=-0,694$ ;  $t=-16,258$ ;  $p<0,001$ ), and low muscular mass ( $\beta=0,146$ ;  $t=3,468$ ;  $p<0,001$ ), can significantly predict diminished lower extremity function.

**Conclusion:** Looking for the presence of OA, Sarcopenia and low percentage of fat free mass is important when monitoring elderly subjects over time once they can predict the decrease in functional ability.

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### AB1198 CLINICAL PROFILE OF HAND OSTEOARTHRITIS IN A LOW INCOME POPULATION

**Keywords:** Descriptive studies, Osteoarthritis, Epidemiology

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**Background:** hand osteoarthritis (HOA) is a highly prevalent disease that may be impacted by social inequalities. However, there are few studies on HOA from underdeveloped regions.

**Objectives:** to present clinical characteristics of a HOA cohort from a low-income population.

**Methods:** clinical data and serum from 70 patients with a diagnosis of HOA fulfilling ACR criteria seen between March 2020 and December 2022 in Fortaleza/ Brazil registering hypertension, diabetes, obesity (BMI>30kg/m<sup>2</sup>), and concurrent diagnosis of knee or spine OA and "bunions"; pain (VAS, visual analogue scale), X-ray (Kellgren-Lawrence) and ultrasonography (US) [synovitis and power-doppler (PD) sign] of the most affected joint of the hand were recorded, as well as grip and pinch strength (KgF), Cochin hand functional scale (CHFS), FIHOA, and SF-12 scores. Social data included income, occupation [white (WCJ) vs. blue (BCJ) color jobs], education level [ $\geq 8$  school-years (SY)].

**Results:** 70 patients were included, comprising 66(94%) women, mean age 60.3 $\pm$ 10.3 with 12(17.1%) below 50 years-old; median disease duration was 72(range 30-120) months. Pain on movement (VAS) was 7.4 $\pm$ 1.9, grip strength 14.5 $\pm$ 6.4, pinch strength 1.7 $\pm$ 1, CHFS 21 $\pm$ 14.8, FIHOA 10.3 $\pm$ 6.2, and SF-12 32.1 $\pm$ 3; 54(77.1%) had KL $\geq 3$ . All but 2 out of 61 evaluated joints had synovitis at US with only 4(6.7%) displaying positive PD signal; 27(38.5%) had isolated HOA; 9(12.8%), 8(11.4%), and 5(7.1%) had concurrent spine or knee OA or bunions, respectively and 22(31.4%) had  $\geq 2$  sites other than HOA; 31(44.2%), 16(22.8%), and 7(10%) had hypertension, obesity and diabetes as comorbidities, respectively; 38(54.2%) declared <900 US\$ monthly family earnings, 8(11.4%) had <8SY and 27(38.5%) had occupations classified as BCJ. Mean pain was similar regardless of occupation, literacy (SY) or monthly family income. Although pain in BCJ group (7.9 $\pm$ 1.7) was higher than in WCJ group (7.1 $\pm$ 2) it did not reach statistical significance ( $p=0.0576$ ); CHFS, FIHOA and SF-12 scores were similar regardless of occupation, SY or income; total mean CRP was 0.41 $\pm$ 0.64 mg/dL; mean CRP in those with concurrent knee OA (0.38 $\pm$ 0.25 mg/dL) had a trend to be higher than in isolated HOA patients 0.24 $\pm$ 0.1 mg/dL ( $p=0.0547$ ).

**Conclusion:** Our results suggest that income and literacy did not influence disease severity in HOA in our low income cohort.

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**Acknowledgements:** NIL.

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### AB1199 PAIN ON WALKING AND PAIN AT REST IN PATIENTS WITH KNEE OSTEOARTHRITIS: IS THERE A DIFFERENCE?

**Keywords:** Osteoarthritis, Pain

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**Background:** The knee osteoarthritis (KOA) pain can be divided into two main categories: pain on walking and pain at rest. A thorough understanding of pain is essential for managing KOA. However, few studies have focused on these two types of pain.

**Objectives:** The objective of this study was to investigate possible factors associated with knee osteoarthritis pain with a focus on the differences between pain on walking and pain at rest.