Methods: This is a cross-sectional study involving patients with knee osteoarthri-
tis. Sociodemographic and clinical data, including comorbidities, were collected.
Neuropathic pain was assessed by the DN4 questionnaire. Neuropathic pain was
defined by a DN4 > 4. Depression, catastrophizing, and central sensitization
were assessed by Arabic versions of validated questionnaires, PCS (Pain Cata-
strophizing 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 aver-
age age was 58.0±9.19 years. 32.7% had neuropathic pain. VAS mean pain was
4.1±2.1. The median duration of evolution was 3.8 years [1-23]. The average
lequesn index was 9.75±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±15. 72.6% of patients had somatization: 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 – 1.13].
However, pain severity, central sensitization, somatization, comorbidities including diabetes
and obesity did not come out as associated factors.

Conclusion: Neuropathic pain is quite common in gonarthrosis. Functional disa-
BILITY seems to be an associated factor.

REFERENCES: NIL.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

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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 inequities. However, there are few studies on HOA from
developed regions.

Objectives: to present clinical characteristics of a HOA cohort from a low-in-
come population.

Methods: clinical data and serum from 70 patients with a diagnosis of HOA ful-
filling ACR criteria seen between March 2020 and December 2022 in Fortaleza/
Brazil registering hypertension, diabetes, obesity (BMI≥30kg/m²), and concur-
rent diagnosis of knee or spine OA and “bunions”; pain (VAS, visual analogue scale), X-ray (Kellgren-Lawrence) and ultrasonography (US) [synovitis and pow-
er-central (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) collar jobs), education level (≥8 school-years (SY)), and monthly
income.

Results: 70 patients were included, comprising 66 (94%) women, mean age 60.3±10.3
with 12(17%) below 50 years-old; median disease duration was 72(range 30-120)
months. Pain on movement (VAS) was 7±4, grip strength 14.5±6, pinch strength
1.7±1, CHFS 21±4, FIHOA 10.3±2, and SF-12 32±1.5; 54(77%) had KL≤3. All but 2
of 61 evaluated joints had synovitis at US with only 4(6.7%) displaying posi-
tive PD signal; 27(38.5%) had isolated HOA; 9(12.6%), 8(11.4%), and 12(17.1%)
had concurrent shoulder or knee OA, and 5(7.1%) had hand arthritis only. Prevalence of OA
was 31(44.2%), 16(22.6%), 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, income (lower SY) OR by monthly family income.
Although pain in BCJ group (79±17) was higher than in WCJ group (71±2) it did not reach statistical
significance (p=0.0576); CHFS, FIHOA and SF-12 scores were similar regardless of
occupation, SY or income; overall mean CRP was 0.41±0.64mg/dL; mean CRP in those
with concurrent knee OA (0.38±0.25mg/dL) had a trend to be higher than in isolated
HOA patients 0.24±0.1mg/dL (p=0.0547).

Conclusion: Our results suggest that income and literacy did not influence dis-
ease severity in HOA in our low income cohort.

REFERENCES: NIL.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

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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 asso-
ciated with knee osteoarthritis pain with a focus on the differences between pain
on walking and pain at rest.
Methods: Cross-sectional study including 87 patients. All demographic data and visual analog scale (VAS) score at walking, VAS score at rest, Kellgren and Lawrence (KL) stage on radiography, and results of clinical examination were collected. Exclusion criteria were the presence of a total knee prosthesis and patients followed for chronic inflammatory rheumatism. Statistical data analysis was performed using SPSS version 21 software.

Results: This study included 87 patients followed for KOA, with an average age of 63.67±5.8 years (46-83 years), and a female predominance (78.3%). In the univariate analyses, significant correlations were found between the VAS score at walking with age (r=0.56, p=0.037), body mass index (BMI) (r=0.61, p=0.023), KL grade (r=0.54, p=0.039) and patellar shock (r=0.46, p=0.044). While the VAS score at rest was only correlated with BMI (r=0.26, p=0.01). And an association between VAS at rest and skin hyperalgesia was noted (p=0.034). The multivariate analysis showed that the significant explanatory factors of the VAS score on walking were BMI > 25 kg/m² (p=0.03) and KL grade >3 (p=0.03). On the other hand, no significant explanatory factor for the VAS score at rest was found.

Conclusion: Predisposing factors were significantly different between the two types of pain, indicating the presence of different pain mechanisms. Pain on walking was more strongly associated with mechanical and structural factors, whereas pain at rest was associated with knee hyperalgesia.

References:

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

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WAIST CIRCUMFERENCE AND GONARTHROSIS

Keywords: Osteoarthritis

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Background: Overweight, translated into a high body mass index (BMI), is an important risk factor for gonarthrosis, thus this risk is increased by 15% for each increase of a unit of body mass index (BMI). (1) Various studies indicate that the association of high BMI and abdominal obesity measured by waist circumference leads to increased morbidity especially in obese. But no study has so far shown a sufficiently strong association force between waist circumference and gonarthrosis.(2,3)

Objectives: The objective of our study is to assess the relationship between waist circumference and pain perception and gonarthrosis impact.

Methods: This work included patients followed in consultation for gonarthrosis. For each patient we specified next to the demographic data, the BMI, the waist circumference, and the presence or absence of pain of the knee or both. The intensity of pain was assessed by the Analog Visual Scale (EVA). Functional impact was assessed by the Lequesne index and WOMAC score. Knee X-rays were classified according to Kellgren Lawrence (KL) criteria.

Results: A total of 209 patients were included (24 men/185 women). The average age was 57.94±9.01 years. The average body mass index was 25.15±5.47 kg/ m² and the average BMI was 93.45±12.35 cm. The average pain EVA at rest was 1.95±2.53 and at stress 7.89±1.30. WOMAC’s average score was 12.3±8.92 and 8.29±5.19. Lequesne’s average score was 67.1 ± 20.1. WOMAC SCORE was significantly higher in gonarthrosis patients with a high waist circumference (p = 0.02). A positive correlation was found between the resting and stress pain EVA and the waist circumference of gonarthrosis patients with respectively (p=0.04, p=0.002). But it is statistically insignificant between the radiographic stages, the lequesne index and waist circumference with (p=0.11, p=0.06, respectively).

Conclusion: The waist circumference seems to be a predictive factor of the presence of gonalgie and a significant functional impact.

References:

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

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Table 1. Predicted pain and KOOS12/HOOS12 Function subscale by analgesic use category (adjusted for sex, age, education, place of residence, index joint, physical activity, body mass index, co-existing conditions, fear of moving and walking difficulties).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>12-week</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS Pain</td>
<td>Non-users</td>
<td>4.5 (4.4, 4.6)</td>
<td>2.8 (2.8, 3.0)</td>
</tr>
<tr>
<td></td>
<td>Persistent users</td>
<td>5.7 (5.6, 5.8)</td>
<td>4.0 (4.0, 4.2)</td>
</tr>
<tr>
<td></td>
<td>Quitters</td>
<td>5.3 (5.2, 5.4)</td>
<td>2.6 (2.5, 2.8)</td>
</tr>
<tr>
<td></td>
<td>New users</td>
<td>4.9 (4.7, 5.1)</td>
<td>4.2 (3.9, 4.4)</td>
</tr>
</tbody>
</table>

KOOS12/HOOS12 Function
|          | Non-users | 59.5 (58.6, 60.3) | 66.3 (65.4, 67.1) | 6.8 (6.0, 7.6) |
|          | Persistent users | 53.7 (52.5, 54.0) | 53.2 (52.0, 54.5) | 6.0 (5.5, 6.9) |
|          | Quitters | 51.6 (50.5, 52.7) | 67.2 (66.0, 68.3) | 15.5 (14.3, 16.8) |
|          | New users | 54.7 (53.0, 56.4) | 65.5 (53.6, 57.3) | 8.8 (9.0, 9.3) |

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