Table 1. Patients showed ≥ 50% reduction in their initial Proteinuria level.

Variable	Group 1 (n=30)	Group 2 (n=30)	P value
4th w	17/30, 56.6%	9/30, 30%	
8th w	20/30, 66.6%	10/30, 33.3%	
12th w	21/30, 70%	13/30, 43.3%	
24th w	23/30, 76.6%	15/30, 50%	

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Clinical aspects and Treatment of axSpA: effects and predictors of effects

OP0054

THE YIELD OF REPEATED ASSESSMENTS IN CHRONIC BACK PAIN PATIENTS SUSPECTED OF EARLY AXIAL SPONDYLOARTHRITIS: TWO-YEAR DATA FROM THE SPONDYLOARTHRITIS CAUGHT EARLY (SPACE) COHORT

Keywords: Real-world evidence, Diagnostic Tests, Spondyloarthritis

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Background: We have shown in the SPACE cohort that a diagnosis of early axial spondyloarthritis (axSpA) can be made in patients with chronic back pain (CBP) of less than two years (2y). However, diagnostic uncertainty can be an obstacle towards initiating disease-modifying treatment. The value of repeated assessments of SpA features for a definite clinical diagnosis is yet to be determined.
Objectives: To assess the yield of repeated assessments of SpA features over 2y to make a *definite axSpA* diagnosis in patients with recent onset CBP referred to the rheumatologist, and to describe the characteristics of patients that change to *definite axSpA* over time.
Methods: We used the 2y data from the SPACE cohort, a European multicentre inception cohort of patients (age <45y) with CBP of recent onset (≥3 months, ≤2y) included from 2009 to 2016. The diagnostic work-up consisted of patient history, physical examination, acute phase reactants (APR) and HLA-B27 testing, radiographs and MRI of the sacroiliac joints (SI-CR and SI-MRI) and spine (not shown). In patients with ≥1 major or ≥2 minor prespecified SpA features, clinical assessments, APR, and imaging were repeated at 1y and 2y visits. At each visit, the rheumatologist reported a clinical diagnosis of *axSpA* or *no axSpA* with level of confidence (LoC; numeric rating scale from 0 (*not confident at all*) to 10 (*very confident*)). Herein, we categorized patients by diagnosis likelihood. At baseline (BL), two categories were defined: 'Definite *axSpA/no axSpA*' when the diagnosis was given with a LoC ≥7 and 'Uncertain *axSpA/no axSpA*' if LOC <7. At 2y, the following categories were defined: 'definite, most likely and possible axSpA' and 'possible, most likely and definite no axSpA' (***Figure 1***). The ASAS classification criteria were applied using central reading. We explored the diagnostic course over 2y. In patients shifting from *no axSpA* (*definite* or *uncertain*) or *uncertain axSpA* at BL to *definite axSpA* at 2y, SpA features were investigated over time.
Results: We included 552 patients. *Definite axSpA* was attributed to 175 (32%) patients at BL and 166 (30%) at 2y (***Figure 1***); 155/175 (89%) and 145/166 (87%) fulfilled ASAS classification criteria, respectively. Of the 175 patients with *definite axSpA* at BL, 133 retained the diagnosis, and only 13 changed to *no axSpA* at 2y. Although still considered as axSpA by the rheumatologist, 29 *definite axSpA* patients at BL were no longer definite axSpA at 2y, due to decrease in LOC to <7 (n=14) or incomplete follow-up (n=15). Overall, the diagnosis changed to *definite axSpA* over 2y in 33 patients (BL: 16 *uncertain axSpA*, 12 *uncertain no axSpA*, and 5 *definite no axSpA*); on average, 3 SpA features were already present at BL and 1 to 2 new SpA features developed over 2y (***Table 1***), with response to NSAIDs and MRI sacroiliitis being the most frequently captured over time.
Conclusion: The yield of repeated assessments of SpA features in patients with CBP suspected of axSpA was modest for the new *definite axSpA* diagnosis at 2y. Most SpA features were already present at BL, with imaging findings and response to NSAIDs appearing as frequent incident SpA features potentially adding to a *definite axSpA* diagnosis over time.

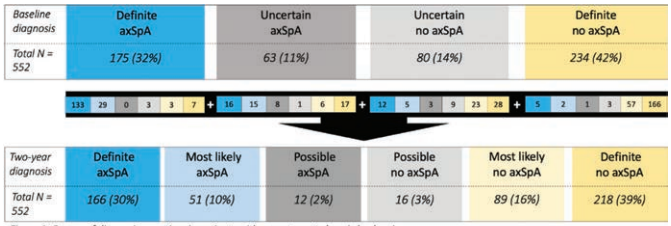

Figure 1. Course of diagnosis over time in patients with recent onset chronic back pain.
Diagnosis definitions at baseline - ***Definite axSpA/no axSpA:*** diagnosis of *axSpA/no axSpA* at baseline with LoC ≥7; ***Uncertain axSpA/no axSpA:*** diagnosis of *axSpA/no axSpA* with LoC <7. **Diagnosis definitions at two years (last observation carried forward approach if two-year visit data was missing)** - ***Definite axSpA:*** diagnosis of *axSpA* with a LoC ≥7 at two years (complete follow-up) or at the two last available visits (missing at the two-year visit); ***Most likely axSpA:*** diagnosis of axSpA with LOC <7 at two years, plus a consistent diagnosis of axSpA in the two last visits (complete follow-up) or diagnosis of axSpA with LoC ≥7 at the last visit only (missing at the two-year visit); ***Possible axSpA:*** diagnosis of *axSpA* with LOC <7 at two years, plus no consistent diagnosis of *axSpA* in the last two visits (complete follow-up) or diagnosis of *axSpA* with LoC <7 at the last visit (missing at the two-year visit); ***Possible no axSpA:*** diagnosis of *no axSpA* with LOC <7, plus no consistent diagnosis of *no axSpA* in the last two visits (complete follow-up) or *no axSpA* diagnosis with LoC <7 at the last visit and no alternative diagnosis reported (missing at the two-year visit); ***Most likely no axSpA:*** diagnosis of *no axSpA* with LOC <7, plus a consistent diagnosis of *no axSpA* in the last two available visits (complete follow-up) or diagnosis of *no axSpA* with LoC ≥7 at the last visit only or if LoC <7, plus an alternative diagnosis reported (missing at the two-year visit); ***Definite no axSpA:*** diagnosis of *no axSpA* with a LoC ≥7 at two years (complete follow-up) or at the two last available visits (missing at the two-year visit).

Table 1. Characteristics of 33 patients changing to *definite axSpA* with newly developed SpA features over 2 years

Baseline diagnosis	Uncertain axSpA at BL N=16		Uncertain no axSpA at BL N=12		Definite no axSpA at BL N=5	
	BL	**2Y**	**BL**	**2Y**	**BL**	**2Y**
Age at inclusion, years	30 (9)	-	35 (8)	-	26 (6)	-
Male	50%	-	75%	-	40%	-
Symptom duration, months	13 (7)	-	12 (7)	-	12 (5)	-
HLA-B27 +	81%	-	58%	-	80%	-
Family history of SpA	8	9	4	5	3	4
Inflammatory back pain§	14	15	7	8	5	5
Good response to NSAIDs	4	10	5	7	3	4
Peripheral manifestations	4	8	2	3	1	2
Extra-musculoskeletal manifestations	4	6	4	5	0	1
Increased acute phase reactants§	4	4	1	3	2	2
SI-CR§	0	0	1	2	0	1
SI-MRI§	3	8	3	5	0	1
Nr of SpA features#	3 (1)	5 (2)	3 (1)	4 (2)	3 (1)	5 (1)
ASAS classification criteria at 2y	-	81%	-	58%	-	80%

Data presented as mean (SD), % or n of patients§local data; #including HLA-B27 and imaging; **BL –** baseline; **SI-CR/MRI –** sacroiliitis on radiographs/MRI

REFERENCES: NIL.
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OP0055

ASAS CONSENSUS DEFINITION OF EARLY AXIAL SPONDYLOARTHRITIS

Keywords: Spondyloarthritis

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Background: There is a growing interest in understanding the early disease stages of axial and peripheral SpA (axSpA and pSpA). In order to facilitate this, standardized definitions are needed for research purposes.
Objectives: To develop a consensual definition for the terms "early axSpA" and "early pSpA" in the research setting under the auspices of the Assessment of SpondyloArthritis international Society (ASAS).
Methods: The ASAS-SPEAR (SPondyloarthritis EARly definition) steering committee convened an international working group (WG). Five consecutive steps were followed: i) Systematic literature review (SLR) to identify existing definitions of early axSpA/pSpA and to summarize the evidence on the relationship between early treatment and clinical response in SpA[1,2]; ii) Discussion of SLR results within the WG and ASAS community (2022 annual meeting); iii) A three-round Delphi survey (Apr-Nov 2022) inviting all ASAS members to select the items that should be considered for the definition of the terms (using a Likert scale 1-9). In total, 20 items relating to three different aspects (axial symptoms, duration of symptoms and radiographic damage involvement) were voted on. Consensus was defined as acceptance or rejection if ≥70% of responses fell within 7-9 or 1-3 on the Likert scale, respectively; iv) Presentation of Delphi survey results to the WG and later to the ASAS community; v) Final discussion, voting and endorsement by ASAS members (2023 annual meeting).
Results: After discussing the results of the SLR[1,2] (step i) with the ASAS community, consensus was to proceed with an expert-based consensual definition for early axSpA (81% full ASAS members voted in favor) but not for pSpA (54% voted against) (step ii). Importantly, it was decided that the definition should be based on the symptom duration (91% in favor) taking solely axial symptoms into account (77% in favor). A total of 151-164/209 (72-78%) ASAS members participated in the Delphi survey rounds (step iii). Consensus was achieved to define early axSpA as a duration of symptoms of ≤2 years. Relating to axial symptoms, consensus was reached for acceptance of 6 items (axial symptoms should include cervical pain, thoracic pain, back pain, buttock pain and morning stiffness and be defined by a rheumatologist) and rejection of 2 items (should not include shoulder pain and hip pain). In addition, consensus was achieved to define early axSpA regardless of the presence/absence of radiographic damage (Table 1). Following the discussion of the Delphi survey results the WG agreed that in patients with a diagnosis of axSpA **"early axSpA" should be defined as a duration of ≤2 years of axial symptoms. Axial symptoms should include spinal/buttock pain or morning stiffness and should be considered by a rheumatologist as related to axSpA, Figure 1.** The WG proposal was discussed and endorsed by the ASAS community with 88% full ASAS members voting in favor (step v).
Conclusion: Early axSpA has for the first time been defined based on expert consensus. This ASAS definition should be used in research studies addressing early axSpA.
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Funding: The Assessment of Spondyloarthritis international Society (ASAS) supported the ASAS- SPEAR (ASAS-SPondyloarthritis EARly definition) project.

Table 1. Delphi survey final results to select radiographic damage involvement items to define early axial spondyloarthritis.

	Third round (n=151)	
	Level of agreement: Likert scale (1-9)	
	1-3	7-9
A patient with axSpA with axial symptoms ≤2 years has early axSpA regardless of the presence or absence of radiographic damage of the SIJ	13%	76%
A patient with axSpA with axial symptoms ≤2 years has early axSpA regardless of the presence or absence of syndesmophytes on x-rays of the spine	20%	70%

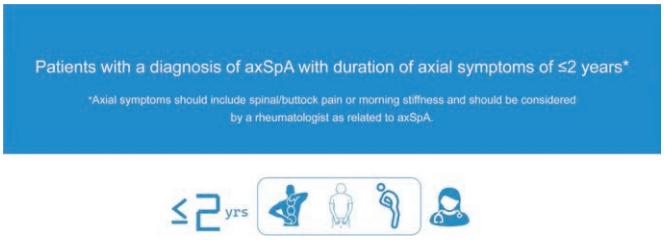

Figure 1. ASAS definition of early axial spondyloarthritis

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OP0056

SENSITIVITY TO CHANGE OF STRUCTURAL LESIONS IN EARLY AXIAL SPONDYLOARTHRITIS AFTER 10 YEARS OF FOLLOW UP. DATA FROM DESIR COHORT

Keywords: Spondyloarthritis, Imaging

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