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Mortality and other outcome measures in osteoarthritis

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Chapter 5

Bone marrow lesions and synovitis
on MRI associate with radiographic
progression after two years in
hand osteoarthritis

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ABSTRACT

OBJECTIVE

To study the association of magnetic resonance (MR) features with radiographic progression of hand osteoarthritis over two years.

METHODS

Of 87 primary hand osteoarthritis patients (82% women, mean age 59 years), baseline distal and proximal interphalangeal joint contrast-enhanced MR images were scored 0-3 for bone marrow lesions (BMLs) and synovitis following the Oslo score.

Baseline and two-year follow-up radiographs were scored following Kellgren-Lawrence (KL) (0-4) and OARSI scoring methods (0-3 osteophytes, joint space narrowing (JSN)). Increase ≥ 1 defined progression.

Associations between MR features and radiographic progression were explored on joint and on patient level, adjusting for age, sex, BMI, synovitis and BML. Joints in end-stage were excluded.

RESULTS

Of 696 analysed joints, 324 had baseline KL=0, 28 KL=4 and after two years 78 joints progressed. BML grade 2/3 was associated with KL progression (2/3 vs 0: adjusted RR (95%CI) 3.3 (2.1-5.3)) and with osteophyte or JSN progression, as was synovitis. Summated scores were associated with radiographic progression on patient level (RR crude BML 1.08 (1.01-1.2), synovitis 1.09 (1.04-1.1), adjusted synovitis 1.08 (1.03-1.1)).

CONCLUSION

BMLs, next to synovitis, show, already after two years, graded associations with radiographic progression, suggesting that both joint tissues could be important targets for therapy.

INTRODUCTION

The hand osteoarthritis (OA) disease process leads to joint destruction, visualised as radiographic damage.¹ With the need to develop effective therapies for hand OA, it is important to understand which processes are involved. By the time radiographic damage is visible, much of the disease process already took place.² Visualisation of the disease process in an earlier stages will facilitate identification of treatment targets and performance of clinical trials.

From ultrasonography studies in hand OA we know that synovial inflammation plays a role in radiographic progression.³⁻⁵ MR has the advantage that subchondral bone can be visualized,⁶ where bone marrow lesions (BMLs) are seen as increased water content in the trabecular bone, compatible with possible inflammation or bone fibrosis and remodelling.^{7,8} In knee OA studies, BMLs were associated with structural progression.^{2,9} In hand OA, one MR study (1.0 Tesla) showed that BMLs, next to synovitis, could predict radiographic progression after 5 years.¹⁰ However, clinical trials in hand OA measure outcome after one or two years follow-up, warranting more data on MR imaging.¹¹

As it is unclear whether underlying processes play the same role in onset (incident) and progression of radiographic osteoarthritic damage,² we studied both together and apart for their association with baseline MR features. Next to the joint level, with summated MR scores we investigated progression on patient level, the level most clinically relevant. This study used for the first time a midterm follow-up of two years.

METHODS

Study design

We used data of HandOSTeoArthritis in Secondary care (HOSTAS), an observational cohort of consecutive patients from our outpatient clinic (a secondary and tertiary referral center enabling inclusion of patients in all disease stages), who were included after the clinical diagnosis of primary hand OA was made by their treating rheumatologist. The present analysis concerns patients who received contrast-enhanced MR imaging, included March 2011 to October 2012.

Exclusion criteria were: any other pathological condition explaining the hand symptoms, secondary OA and routine MR contraindications. Written informed consent was obtained from all participants. The study was approved by the LUMC medical ethics committee.

For clinical assessment see supplement.

Radiographs

Baseline and two-year follow-up radiographs of distal interphalangeal (DIPJs), proximal interphalangeal (PIPJs), interphalangeal (IPJs), metacarpophalangeal (MCPJs) and 1st carpometacarpal joints of both hands (30 joints per patient) were scored 0-4 following Kellgren-Lawrence (KL) scoring and 0-3 (IPJs 0-1) for osteophytes and JSN following the OARSI atlas (MCPJs following the PIPJs atlas).^{12,13} Joints with the highest score or with arthroplasty were in end-stage. Reader WD scored paired in known order, blinded for demographic and clinical data. Intraobserver reliability (based on 10% of pairs), was high: cross-sectional intra-class correlation coefficients (ICC) were 0.89-0.91 and longitudinal percentages exact agreement for progression 92-96% for the different methods.

Radiographic progression was defined as an increase in score above the Smallest Detectable Change (SDC):¹⁴ SDCs on joint level 0.28-0.39, so ≥ 1 grade defined progression. For subanalysis, joints were classified as incident OA when they changed from no OA at baseline (KL score 0) to radiographic osteoarthritic damage (KL score 1-4). Joints progressed when they had signs of OA at baseline (KL score ≥ 1) and increased in score.

Scores of KL (range 0-120), osteophytes or JSN (both 0-86) of all 30 hand joints were summated to study progression on patient level. SDCs were 2.2, 1.4 and 1.8, respectively. Therefore, increase ≥ 3 grades in KL or ≥ 2 grades in osteophyte or JSN summated scores defined progression.

MR Imaging

MR imaging of the right PIPJs and DIPJs (n=8 joints per patient) was performed at baseline, using an ONI-MSK-Extreme 1.5 Tesla (T) extremity MR imaging scanner (GE, Wisconsin, USA), acquiring coronal and axial T1-weighted pre- and post-contrast injection and coronal and axial T2-weighted images (protocol in supplement).

MR imaging scoring was performed blinded for demographic and clinical data by RL, using a modified version of the Oslo hand OA MR imaging scoring.¹⁵ Cross-sectional intra-reader reliability was high: ICC 0.84-1.00 (based on 11 patients).

Synovitis and BMLs were scored 0-3, while effusion, flexor tenosynovitis (PIPJs) or flexor tendon involvement (DIPJs), extensor tendon involvement and cysts were scored present/absent (detailed scoring in supplement).

BML and synovitis scores were summated (range 0-24) for patient level analysis.

Statistical analysis

Risk ratios (RRs) with 95% confidence intervals (CIs) were estimated to study the association of MR features (determinant) with radiographic progression (outcome) on joint level using generalised estimating equations (GEE) to account

for the patient effect (joints within a patient as within-subject variable), while adjusting for age, sex and BMI. An exchangeable working correlation matrix, a log link function and the Poisson distribution with robust standard errors were used.¹⁶ Joints without the MR feature served as reference. BML or synovitis grades 2 and 3 were merged. Joints in radiographic end-stage at baseline, were excluded, as they have no potential for progression.

The association between summated scores of MR features (8 joints) and presence of radiographic progression on patient level (both hands) was studied using the modified Poisson approach for binary data (i.e. a Poisson regression model with robust standard errors).

Statistical software from SPSS for Windows, V.23.0 (IBM SPSS statistics, New York, USA) was used.

RESULTS

Study population and prevalence of imaging features

Baseline MR imaging was performed in 107 patients, whereof 87 (83%) (82% women, mean age 59 years, follow-up time 2.1 years, supplement) had follow-up available. Reasons for no follow-up: 11 patients stopped, 2 were excluded, 5 skipped visit and 2 radiographs missed. Patients with and without follow-up did not differ (not shown).

At baseline, 28 (4%) joints were in end-stage for KL, 38 (6%) for osteophytes and 42 (6%) for JSN. Progression was seen in 12%, 9% and 10% of joints not in end-stage, respectively (supplement). At follow-up, one PIPJ had an arthroplasty and 25 patients showed no progression.

BMLs were present in 14.7% (102/693) of joints, while 41.4% (286/691) had synovitis, with missing data in 3 and 5 joints, respectively. Effusion, flexor- or extensor tendon involvement or cysts were present in 8% (57/693), 3% (20/692), 7% (48/692) and 3% (23/696) of joints, respectively.

MR features and radiographic progression

BMLs grade 2/3 were associated with KL progression (vs 0 RR (95%CI) 3.3 (2.1; 5.3), figure 1, supplement), while BML grade 1 was not. Synovitis showed graded associations with KL progression. Similar results were found for associations with osteophyte and JSN progression (supplement). Adjustment for BMLs decreased the strength of the association between synovitis and progression, and vice versa. Neither effusion (present vs absent RR 0.8 (0.3; 2.0)), nor flexor- (1.1 (0.2; 5.9)), nor extensor tendon involvement (0.9 (0.3; 2.5)) nor cysts (1.3 (0.5; 3.3)) were associated with KL progression.



Figure 1. Radiographic progression of a second distal interphalangeal joint. Radiograph at baseline (A) and after two years (B) with corresponding magnetic resonance features (C, D) at baseline.

- A. Dorsovolar conventional radiograph at baseline shows discrete joint space narrowing and subchondral cyste formation on the medial side.
- B. Dorsovolar conventional radiograph after two years shows progression of joint space narrowing, subchondral cyst- and osteophyte formation.
- C. Axial T1-weighted fast spin echo (FSE) image with frequency-selective fat-suppression (FSFS) post-Gd at baseline, shows synovial enhancement (synovitis grade 2) at the dorsal side (arrow).
- D. Coronal T2-weighted FSE image with FSFS at baseline, shows high signal in the trabecular bone (bone marrow lesion grade 2) (arrow).

MR features and onset or progression of radiographic osteoarthritic damage

Of joints that increased in KL score, 33 had baseline KL=0 (incident OA), while the other 45 joints had baseline KL \geq 1 (prevalent OA). Both BML and synovitis were associated with onset and progression and these associations were similar in strength (table 1).

Table 1. Baseline Magnetic Resonance (MR) imaging features associated with radiographic progression in the same joint[#] after two years of follow-up in 87 patients with hand osteoarthritis in the HOSTAS cohort, stratified to the presence radiographic osteoarthritic damage at baseline.

1a. In 324 joints with no radiographic osteoarthritic damage at baseline (KL= 0), i.e. incident radiographic damage.

MR feature (joint)	Number of joints with progression/total (% progressed)	Crude RR (95% CI)	Adjusted RR (95% CI)*	Adjusted RR (95% CI)**
BML				
Grade 0, absent	29/309 (9)	1	1	1
Grade 1	2/12 (17)	1.9 (0.5 to 6.8)	2.0 (0.5 to 7.0)	1.6 (0.6 to 4.2)
Grade 2 + 3	2/3 (67)	6.8 (3.1 to 15.1)	8.8 (3.5 to 22.0)	4.3 (1.4 to 13.5)
Present	4/15 (27)	2.9 (1.2 to 7.2)	3.1 (1.3 to 7.3)	2.6 (1.4 to 5.0)
Synovitis				
Grade 0, absent	17/248 (7)	1	1	1
Grade 1	12/67 (18)	2.6 (1.4 to 5.0)	2.6 (1.4 to 5.0)	2.6 (1.4 to 5.0)
Grade 2 + 3	4/8 (50)	7.0 (3.0 to 16.1)	7.2 (3.1 to 16.7)	5.1 (2.1 to 12.3)
Present	16/75 (21)	3.1 (1.6 to 5.8)	3.1 (1.7 to 5.8)	3.0 (1.6 to 5.5)

1b. In 344 joints, not in end-stage, with progression of radiographic osteoarthritic damage (KL baseline = 1 to 3).

MR feature (joint)	Number of joints with progression/total (% progressed)	Crude RR (95% CI)	Adjusted RR (95% CI)*	Adjusted RR (95% CI)**
BML				
Grade 0, absent	25/273 (9)	1	1	1
Grade 1	8/51 (16)	1.8 (0.8 to 3.7)	1.7 (0.8 to 3.6)	1.3 (0.6 to 2.6)
Grade 2 + 3	11/17 (65)	7.2 (4.5 to 11.4)	7.3 (4.7 to 11.6)	3.5 (2.1 to 6.0)
Present	19/68 (28)	3.1 (1.9 to 5.1)	3.0 (1.8 to 4.9)	2.5 (1.5 to 4.1)
Synovitis				
Grade 0, absent	8/149 (5)	1	1	1
Grade 1	12/119 (10)	2.0 (0.8 to 4.9)	2.0 (0.8 to 5.0)	1.9 (0.8 to 4.7)
Grade 2 + 3	24/72 (33)	6.4 (2.9 to 13.8)	6.2 (2.8 to 13.6)	4.2 (1.8 to 9.9)
Present	36/191 (19)	3.6 (1.7 to 7.5)	3.5 (1.6 to 7.5)	3.0 (1.4 to 6.6)

*model adjusted for age, sex and Body Mass Index (BMI).

**model adjusted for age, sex, BMI, BML and synovitis.

[#]Due to no information, 5 and 3 joints were not taken into account in the synovitis and BML analysis, respectively. Joints in radiographic end-stage at baseline were excluded from the analysis, as they had no potential for progression.

KL = Kellgren-Lawrence, BML = bone marrow lesion, RR = Risk Ratio, CI = confidence interval.

Summated MR features and progression on patient level

Median (range) summated BML score was 1 (0; 10) and synovitis score was 4 (0; 13). Both BML and synovitis summated scores were crudely associated with

progression. However, after adjustment, only the associations for synovitis remained statistically significant (table 2).

Table 2. Associations between summated scores of Magnetic Resonance (MR) imaging features and progression of radiographic osteoarthritis on patient level in 87 hand osteoarthritis patients*.

MR feature	KL progression (95% CI)	Osteophyte progression (95% CI)	JSN progression (95% CI)
Patients with progression/total	44/87	47/87	34/87
BML (0-24)			
Crude RR	1.08 (1.01 to 1.2)	1.05 (0.98 to 1.1)	1.11 (1.02 to 1.2)
RR adjusted for synovitis	1.00 (0.9 to 1.1)	1.01 (0.9 to 1.1)	1.00 (0.9 to 1.1)
RR adjusted age, sex and BMI	1.06 (0.99 to 1.1)	1.07 (0.98 to 1.2)	1.11 (1.01 to 1.2)
Synovitis (0-24)			
Crude RR	1.09 (1.04 to 1.1)	1.05 (1.004 to 1.1)	1.13 (1.1 to 1.2)
RR adjusted for BML	1.09 (1.04 to 1.2)	1.05 (0.99 to 1.1)	1.12 (1.05 to 1.2)
RR adjusted age, sex and BMI	1.08 (1.03 to 1.1)	1.07 (1.02 to 1.1)	1.14 (1.1 to 1.2)

*RR's should be interpreted as increased risk per point increase in summated BML or synovitis scores. E.g. Our observed range for summated BML score was 0-10, so patients with the highest BML score have a $1.08^{10}=2.16$ times (216%) higher risk for KL progression than patients without any BML
KL = Kellgren Lawrence, JSN = joint space narrowing, CI = Confidence Interval, BML = bone marrow lesion, RR = Risk Ratio, BMI = Body Mass Index

DISCUSSION

MR imaging-defined BMLs, like synovitis, showed dose-response associations with radiographic progression in hand OA already after 2 years, confirming earlier studies on ultrasound-detected synovitis,³ but indicating that BMLs in hand OA, like in knee OA,^{2,9} are an important additional factor in the disease process. Also, because presence of BMLs decreases the strength of the association between synovitis and progression, and vice versa.

A strength of our study is inclusion of patients in all disease stages from early to severe. Other cohorts have more severely affected hand OA patients with more joints in end-stage at baseline;^{3,10} these joints have no potential for onset of OA or progression and are thus excluded from the analysis.

Another strength is the distinction in onset and progression of radiographic damage in individual hand joints. Of note, this distinction resulted in few joints in some groups and therefore results should be interpreted with caution. We used a cut-off at doubtful to definite OA (KL 1), since lesions can already be present at KL=1. Like in knees, where KL=1 at baseline was a strong predictor for progression

and considered as early OA.¹⁷ We showed that both BML and synovitis were associated with onset and progression and that these associations were similar in strength. This is in line with results for ultrasound-detected synovitis,⁴ but was not described before in MR-detected BMLs and synovitis.

Novel is our approach to investigate progression on patient level, which is most relevant from a clinical perspective. Summated BML or synovitis score showed crude associations with progression, although only for synovitis this remained statistically significant after adjustment. This means that the more severe the inflammatory state is, the higher the risk of progression in both hands. We hypothesize that inflammatory MR imaging features could be modified by anti-inflammatory medication like steroids. Future proof-of-concept randomised controlled trials could explore this hypothesis.

This is the first study using 1.5 Tesla MR scanner in hands, enabling more precise identification of lesions with a higher signal-to-noise ratio compared to 1.0 Tesla. Consequences are indicated by our results: we found an association between JSN progression and synovitis grade 1, where another hand OA MR study using 1.0 Tesla did not.¹⁰

Our study also had some limitations and restrictions in interpretation of results. First, we did not have information whether MR imaging features are persistent or fluctuating. Especially persistent or progressing lesions have shown to be associated with progression and onset of OA.^{3,18,19} Nevertheless, we already found the association with only one time measurement. Another limitation is the number of patients in our study. However, the circumstance that in every patient 8 joints can be studied provided enough power to study associations with progression.

Our study indicates that all joints tissues, including BMLs, are important in the disease course of hand OA and it illustrates the use of MR imaging, visualizing BMLs, in detecting early OA and detection of joints and patients prone to progress. Future studies should focus on the persistent or fluctuant nature of BMLs in hands and on hand MR imaging on the short term.

REFERENCES

- 1 Kloppenburg M, Kwok W-Y. Hand osteoarthritis--a heterogeneous disorder. *Nat Rev Rheumatol* 2012;8:22–31.
- 2 Ding C, Zhang Y, Hunter D. Use of imaging techniques to predict progression in osteoarthritis: *Curr Opin Rheumatol* 2013;25:127–35.
- 3 Kortekaas MC, Kwok W-Y, Reijnierse M, et al. Inflammatory ultrasound features show independent associations with progression of structural damage after over 2 years of follow-up in patients with hand osteoarthritis. *Ann Rheum Dis* 2014;:annrheumdis – 2013–205003.
- 4 Mathiessen A, Slatkowsky-Christensen B, Kvien TK, et al. Ultrasound-detected inflammation predicts radiographic progression in hand osteoarthritis after 5 years. *Ann Rheum Dis* Published Online First: 1 April 2015.
- 5 Mancarella L, Addimanda O, Pelotti P, et al. Ultrasound detected inflammation is associated with the development of new bone erosions in hand osteoarthritis: a longitudinal study over 3.9 years. *Osteoarthritis Cartilage* 2015;23:1925–32.
- 6 Guermazi A, Roemer FW, Hayashi D. Imaging of osteoarthritis: update from a radiological perspective. *Curr Opin Rheumatol* 2011;23:484–91.
- 7 Schett G. Bone Marrow Edema. *Ann N Y Acad Sci* 2009;1154:35–40.
- 8 McQueen F. A vital clue to deciphering bone pathology: MRI bone oedema in rheumatoid arthritis and osteoarthritis. *Ann Rheum Dis* 2007;66:1549–52.
- 9 Roemer FW, Zhang Y, Niu J, et al. Tibiofemoral Joint Osteoarthritis: Risk Factors for MR-depicted Fast Cartilage Loss over a 30-month Period in the Multicenter Osteoarthritis Study1. *Radiology* 2009;252:772–80.
- 10 Haugen IK, Slatkowsky-Christensen B, Bøyesen P, et al. MRI findings predict radiographic progression and development of erosions in hand osteoarthritis. *Ann Rheum Dis* 2014;:annrheumdis – 2014–205949.
- 11 Kloppenburg M, Maheu E, Kraus VB, et al. OARSI Clinical Trials Recommendations: Design and conduct of clinical trials for hand osteoarthritis. *Osteoarthritis Cartilage* 2015;23:772–86.
- 12 Kellgren JH, Lawrence JS. Radiological Assessment of Osteo-Arthrosis. *Ann Rheum Dis* 1957;16:494–502.
- 13 Altman RD, Gold GE. Atlas of individual radiographic features in osteoarthritis, revised. *Osteoarthritis Cartilage* 2007;15, Supplement 1:A1–56.
- 14 Bruynesteyn K, Boers M, Kostense P, et al. Deciding on progression of joint damage in paired films of individual patients: smallest detectable difference or change. *Ann Rheum Dis* 2005;64:179–82.
- 15 Haugen IK, Lillegraven S, Slatkowsky-Christensen B, et al. Hand osteoarthritis and MRI: development and first validation step of the proposed Oslo Hand Osteoarthritis MRI score. *Ann Rheum Dis* 2011;70:1033–8.
- 16 Knol MJ, Cessie SL, Algra A, et al. Overestimation of risk ratios by odds ratios in trials and cohort studies: alternatives to logistic regression. *Can Med Assoc J* 2012;184:895–9.
- 17 Klerk BM de, Willemsen S, Schiphof D, et al. Development of radiological knee osteoarthritis in patients with knee complaints. *Ann Rheum Dis* 2012;71:905–10.

- 18 Hunter DJ, Zhang Y, Niu J, et al. Increase in bone marrow lesions associated with cartilage loss: A longitudinal magnetic resonance imaging study of knee osteoarthritis. *Arthritis Rheum* 2006;54:1529–35.
- 19 Sharma L, Nevitt M, Hochberg M, et al. Clinical significance of worsening versus stable preradiographic MRI lesions in a cohort study of persons at higher risk for knee osteoarthritis. *Ann Rheum Dis* 2016;75:1630-6.

SUPPLEMENT

MRI protocol

MR imaging was performed using an ONI-MSK-Extreme 1.5 Tesla (T) extremity MR imaging scanner (GE, Wisconsin, USA). The right hand PIPJs and DIPJs (n=8 joints) of each patient were examined, regardless of clinical features or dominance.

The following sequences were used: coronal T1-weighted (T1-w) fast spin echo (FSE) images (repetition time (TR)/echo time (TE) 575/11 milliseconds (ms), acquisition matrix (AM) 388×288, echo train length (ETL) 2, minimum TE), axial T1-w FSE images (TR/TE 500/10.2 ms, AM 340×288, ETL 2, minimum TE), coronal T2-w FSE images with frequency-selective fat-saturation (FSFS) (TR/TE 3000/61.8 ms, AM 300×224, ETL 7) and axial T2-w FSE images with FSFS (TR/TE 3000/57 ms, AM 336×192, ETL 7) before contrast injection, and coronal T1-w FSE images with FSFS (TR/TE 600/10.4 ms, AM 364×224, ETL 2, minimum TE) and axial T1-w FSE images with FSFS (TR/TE 650/7.7 ms, AM 320×192, ETL 2, minimum TE) after intravenous injection of gadolinium-chelate (Gd) (gadoteric acid, Guerbet, France, standard dose 0.1 mmol/kg). Coronal images had a field of view (FOV) of 120 mm and 18 slices with slice thickness 2 mm and slice gap 0.2 mm. Axial sequences had a FOV of 100 mm and 24 slices with slice thickness 3 mm and slice gap 0.3 mm. Total acquisition time was 30 minutes.

MRI scoring

MR imaging scoring was performed using a modified version of the Oslo hand OA MR imaging scoring. Effusion and extensor tendon involvement (see definition) were added to the scoring. As there is no tendon sheath around the extensor tendon on PIPJ and DIPJ level or around the flexor tendon on DIPJ level*, we renamed tenosynovitis to involvement.

BMLs, synovitis, flexor tenosynovitis and cysts were scored in the same manner as described in the atlas, using T2-weighted images instead of STIR. Data for flexor pathology were dichotomized in presence and absence after scoring.

Synovitis was defined as an area in the synovial compartment showing post-Gd enhancement (on T1-w post-Gd images) of a thickness greater than the width of synovium (≥ 1 mm). Score 0 = no synovitis; 1 = mild, 1/3 of synovium thickened; 2 = moderate, 2/3 thickened; 3 = severe, all synovium thickened.

BMLs were defined as lesions within the trabecular bone with signal characteristic consistent with increased water content on T2-w images: 0 = no BML, 1 = 1-33% of bone with BML, 2 = 34%-66% with BML, 3 = 67%-100% with BML. Distal and proximal joint sites were scored separately and the highest score was taken as the score for the whole joint.

Effusion, fluid in the joint, was present when an area showed increased signal

intensity on T2-w images, non-enhancing on T1-w post-Gd images and only when synovitis was present.

Flexor tenosynovitis (PIPJs) or flexor tendon involvement (DIPJs) was present when an area in the flexor tendon (sheath) showed post-Gd enhancement on T1-w images more than normally expected.

Extensor tendon involvement was present when opposite sides of the tendon showed post-Gd enhancement on T1-w images more than normally expected.

Cysts were defined as sharply marginated bone lesions without a cortical break with low signal on T1-w pre-Gd images and high signal on T2-w images.

*Nieuwenhuis WP, Krabben A, Stomp W, *et al.* Evaluation of Magnetic Resonance Imaging–Detected Tenosynovitis in the Hand and Wrist in Early Arthritis. *Arthritis Rheumatol* 2015;**67**:869–76. doi:10.1002/art.39000

Clinical assessment

Demographic and disease characteristics were collected by standardised questionnaires. Self-reported hand pain was assessed by visual analogue scale (range 0-100 millimeter). Self-reported hand function (0-30) was assessed by the Functional Index for Hand OsteoArthritis (FIHOA)*. Higher scores indicate worse health.

Physical examination was performed by a trained research nurse, assessing the distal interphalangeal joints (DIPJs), proximal interphalangeal joints (PIPJs), interphalangeal joints, metacarpophalangeal joints (MCPJs) and 1st carpometacarpal joints of both hands (n=30 joints per patient) for tenderness upon palpation and bony and soft swelling.

* Wittoek R, Vander Cruyssen B, Maheu E, *et al.* Cross-cultural adaptation of the Dutch version of the Functional Index for Hand Osteoarthritis (FIHOA) and a study on its construct validity. *Osteoarthritis Cartilage* 2009;**17**:607–12. doi:10.1016/j.joca.2008.10.006

Supplementary table 3. Baseline characteristics of 87 hand osteoarthritis (OA) patients with available contrast-enhanced magnetic resonance imaging at baseline and follow-up radiographs from the HOSTAS cohort.

Patient level, 87 patients	
Age, mean (SD), years	59.4 (7.6)
BMI, mean (SD), kg/m ²	27.3 (4.4)
Women, number (%)	71 (82)
Self-reported symptom duration, median (range), years	5.5 (0.3 to 36.8)
Dominance, n (%)	
- Right	63 (72)
- Unclear	8 (9)
Fulfilling ACR criteria*, number (%)	80 (92)
VAS pain, mean (SD), 0-100 [^]	
- Right hand	33.6 (21.4)
- Left hand	33.9 (22.5)
Self-reported function, median (range), 0-30	8 (0 to 24)
Median number of involved joints per patient (range)	
- Tender joints upon palpation 0-30	3 (0 to 24)
- Bony swellings 0-30	12 (0 to 22)
- Soft swellings 0-30	0 (0 to 17)
Radiographic erosive disease**, n of patients (%)	26 (30)
Joint level, 696 joints (n=8 per patient)	
Physical exam findings, n/total (%)	
- Tenderness upon palpation	120/696 (17)
- Bony swelling	420/696 (60)
- Soft swelling	49/696 (7)

BMI = body mass index, ACR = American College of Rheumatology, VAS = visual analogue scale.

[^]n=86

*Altman R, Alarcon G, Appelrouth D, *et al.* The American College of Rheumatology criteria for the classification and reporting of osteoarthritis of the hand. *Arthritis Rheum* 1990;**33**:1601–10.

Erosive disease was present when having ≥1 joint with an eroded or remodelled subchondral plate following Verbruggen-Veys anatomical phase scoring (Verbruggen G, Veys EM. Numerical scoring systems for the anatomic evolution of osteoarthritis of the finger joints. *Arthritis Rheum* 1996;39**:308–20).

Supplementary table 4. Baseline Magnetic Resonance (MR) imaging features associated with radiographic progression in the same joint[#] after two years of follow-up in 87 patients with hand osteoarthritis in the HOSTAS cohort.

MR feature (joint)	Number of joints with progression/ total (% progressed)	Crude RR (95% CI)	Adjusted RR (95% CI)*	Adjusted RR (95% CI)**
Kellgren-Lawrence progression				
BML				
Grade 0	54/582 (9)	1	1	1
Grade 1	10/63 (16)	1.7 (0.8 to 3.3)	1.6 (0.8 to 3.2)	1.2 (0.7 to 2.1)
Grade 2 + 3	13/20 (65)	6.9 (4.7 to 10.1)	7.2 (4.9 to 10.6)	3.3 (2.1 to 5.3)
Synovitis				
Grade 0	25/397 (6)	1	1	1
Grade 1	24/186 (13)	2.1 (1.2 to 3.6)	2.2 (1.3 to 3.7)	2.1 (1.2 to 3.6)
Grade 2 + 3	28/80 (35)	5.6 (3.4 to 9.3)	5.7 (3.4 to 9.5)	4.0 (2.2 to 7.1)
Osteophyte progression				
BML				
Grade 0	41/577 (7)	1	1	1
Grade 1	9/61 (15)	2.0 (0.8 to 4.9)	2.0 (0.8 to 4.8)	1.4 (0.7 to 3.0)
Grade 2 + 3	10/17 (59)	7.9 (4.4 to 14.2)	8.7 (5.0 to 15.1)	3.7 (2.2 to 6.4)
Synovitis				
Grade 0	15/397 (4)	1	1	1
Grade 1	23/182 (13)	3.6 (1.9 to 7.1)	3.6 (1.8 to 7.3)	3.4 (1.7 to 6.8)
Grade 2 + 3	22/74 (30)	8.3 (4.5 to 15.4)	8.3 (4.2 to 16.1)	5.7 (3.0 to 11.1)
Joint space narrowing progression				
BML				
Grade 0	46/580 (8)	1	1	1
Grade 1	11/60 (18)	1.8 (0.8 to 3.9)	1.8 (0.8 to 3.9)	1.3 (0.6 to 2.8)
Grade 2 + 3	9/11 (82)	7.7 (4.3 to 13.8)	7.8 (4.2 to 14.5)	3.5 (1.7 to 7.2)
Synovitis				
Grade 0	20/394 (5)	1	1	1
Grade 1	23/184 (13)	2.3 (1.3 to 4.1)	2.3 (1.3 to 4.1)	2.1 (1.1 to 3.9)
Grade 2 + 3	23/71 (32)	5.5 (2.9 to 10.6)	5.5 (2.7 to 11.1)	3.5 (1.7 to 7.4)

*model adjusted for age, sex and Body Mass Index (BMI).

**model adjusted for age, sex, BMI, BML and synovitis. The JSN analysis was also adjusted for presence of baseline JSN (score \geq 1).

[#]Due to no information, 3 and 5 joints were not taken into account in the BML and synovitis analysis, respectively. Joints in radiographic end-stage at baseline were excluded from the analysis, as they had no potential for progression.

BML = bone marrow lesion, RR = Risk Ratio, CI = confidence interval.

