hands (23.5%). Lung involvement was defined by HRCT compatible with ILD (64.7%) and abnormal functional exploration (47.1%): restrictive pattern (87.5%) and diminished DLCO (61%). Muscle involvement was defined by elevated CK (52.9%) with a median maximum value of 517 IU/L, myopathic pattern on 8 of 13 performed EMG (61.1%) with myositis found in 4 of them (50%), and inflammatory myositis in 5 of 8 performed biopsies (62.5%). Anti-ARS findings were anti-Jo1 (11), PL12 (2), PL7 (1), anti-EJ (2) and one patient with both PL7 and PL12. Anti-Jo1 predominant clinical pattern was ILD (72.7%), followed by myopathy (63.6%) and concomitant myopathy and ILD (45.5%). Anti-PL12 was associated with ILD, RP, and esophageal involvement and no myopathy. Anti-PL7 patient showed mild myopathy and cutaneous association alone. A combination of anti-PL12 and PL7 was described in one patient who developed ILD with severe myopathy. Anti-EJ patients had pulmonary involvement but no evidence of muscle disease. There was no evidence of cancer in any of our patients. Corticosteroids therapy was administered in most of them (88.2%), and corticodependence was highlighted, being necessary at times to associate one or more immunosuppressants.

Conclusions: Regardless of ASS being a rare disease, 17 patients were collected. Anti-Jo1 was the most described antibody. It is important to note that one patient was found to be positive for both anti-PL7 and PL12 meanwhile they were described as exclusive, showing overlap of clinical pattern with severe muscle injury. This finding suggests that positive results for more than one ASS antibody infer more severity. In contrast with previous literature, pulmonary was more frequent than muscle involvement. The coexistence of both was observed in a small group (35.3%), mostly in anti-Jo1 patients (45.5%). Therefore, we suggest the need to request ASS antibodies in patients with pulmonary or/and muscle involvement at onset although classic clinical pattern is missing.

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Disclosure of Interest: None declared

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AB0615 PERSISTENCE OF HUMAN PAPILLOMAVIRUS IN THE CERVIX OF WOMEN WITH SYSTEMIC SCLEROSIS

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Background: Persistent infection by high-risk oncogenic Human Papillomavirus (HPV) is the main cause of the development of dysplastic or malignant lesions of the cervix. Furthermore, a few life habits, such as smoking, sexual habits and hormonal contraception, are known risk factors for cervical HPV infection. In addition, increased frequency of persistent HPV infection or high-grade intra-epithelial lesions rates was anecdotally described in patients affected by immune-mediated diseases, such as systemic lupus erythematosus, rheumatoid arthritis and systemic sclerosis (SSc), in comparison with the general population.

Objectives: To determine the prevalence of persistent HPV infection in an SSc patients series and its possible correlation with the disease clinical features.

Methods: The study retrospectively evaluated 52 consecutive female SSc patients (age 56.7±11.2SD years, disease duration 12.1±7.4SD years), classified according to the ACR/EULAR 2013 criteria, referring to our university-based Rheumatology Unit. Detection of HPV DNA and viral genotyping in cervical swabs were carried out. Moreover, abnormal Papanicolau test smears were classified using the Bethesda system.

Results: Fourteen(26.9%) patients presented a cervical swab positive for HPV infection,including12 infected by high risk or probable-high risk HPV types. Six (11.5%) patients presented multiple infection ($\geq$2 HPV types), including one case with high-grade intra-epithelial lesion.

Only tabagism was significantly correlated to HPV infection; namely,smoking habit was observed in 41.6% of SSc patients with and in 21.7% of those without HPV infection, respectively; p=0.006); moreoverimmunesuppressive therapies, namely mofetil mycophenolate, cyclophosphamide or rituximab, tended to be associated withHPV infection (presence/absence 21.4 vs 21.7%; p=0.055).

More interestingly, amongSSc patients over 50, HPV infection was found in 9/38 (23.7%) individuals, a frequency markedly higher than that expected in age-matched general population from the same geographical area (5%).

Conclusions: Persistent HPV infection was observed in over a quarter of SSc patients, notably in women over 50. The HPV positivity was not related to SSc clinical features, while a significant association with tabagism and immunesuppressive therapies was evidenced. Considering the possible clinico-prognostic implication on the overall disease outcome, routinely gynaecological screening of SSc female patients ishighly recommendable.

Disclosure of Interest: None declared

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AB0616 COST ANALYSIS RELATED TO SUBCUTANEOUS IMMUNOGLOBULINS IN PATIENTS WITH INFLAMMATORY MYOPATHIES AND IMMUNE-MEDIATED CHRONIC NEUROPATHIES. RESULTS OF AN OPEN LABEL STUDY

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Background: Intravenous Immunoglobulins (IVIg) represent a relevant treatment option in various immune-mediated disorders such as idiopathic inflammatory muscle diseases (IIMD), immune-mediated chronic neuropathies (IMCN), hematologic autoimmune diseases, Still disease, Felty syndrome, systemic lupus erythematosus, vasculitis, some organ-specific autoimmune disease, and atopic diseases. The IVIg treatment is expensive and need of hospital-based assistance for administration; the recent avaibility of home-therapy with subcutaneous immunoglobulins (SCIg) may significantly reduce costs and improve the patient's quality of life.

Objectives: The primary objective was to perform an analysis of costs of SCIg administration in patients affected by IIMD or IMCN compared to that of previous IVIg treatments.

Methods: We prospectively evaluated 6 consecutive patients (3 males and 3 females, mean age 65,3 years, range 63 - 77), 2 affected by IIMD in the context of polymiositis and 4 by IMCN, 3 in the context of vasculitis and 1 in the context of undifferentiated connective tissue disease. All patients were previously treated with IVIg at the dosage of 2g/Kg monthly, (mean monthly dosage 143 g, range 98 – 160, average patient weight 71,5 kg, range 49 - 80), with good clinical and humoral response. After a mean therapy duration of 49.8 months (range 12 – 125) all patients were shifted to SCIg at the dosage of 10 g twice a week (80 g monthly). Each patient was followed-up by humoral and clinical evaluation, including Medical Research Council (MRC) score to quantify muscle strength and INCAT Sensory Score to evaluate sensory symptoms. The costs of the two therapeutic strategies were also compared, excluding indirect costs (absences from work and productivity losses, transport and parking, health care sector costs).

Results: In 5/6 patients, we observed the maintenance of clinical and humoral status after a mean follow-up of 21 months (range 4 - 51), in particular we observed a stability in MRC score in patients presenting loss of strenght and INCAT score in patients presenting sensory symptoms. Furthermore, the treatment with SCIg was well-accepted and preferred to IVIg by all patients. In one patient SCIg were discontinued after 2 weeks, because of the appearance of a haemorrhagic lesions nearby the injection site (in the same patient IVIg have been stopped because of a hypertensive crisis during the infusion). Direct cost associated to IVIg amount to 252€ for 5 g of immunoglobulins (7,056€ monthly, considering a protocol of 2 g/kg/monthly and a patient-weight of 70kg), while direct costs associated to SCIg (20g weekly) amount to 6,400€/monthly, with a saving of 656€/monthly and 7,872€/yearly. In our case-series the annual saving was 9,686.40€/patient (from 86,486.40€ to 76,800€, for IVIg and SCIg, respectively).

Conclusions: Our experience suggests that the shift to SCIg from IVIg in patients affected by IIMD and IMCN is feasible, cost-effective, safe and well-accepted by patients. Further studies are needed to evaluate the effectiveness of SCIg in first-line therapy of these diseases.

Disclosure of Interest: None declared

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AB0617 CLINICAL CHARACTERISTICS OF DIABETES MELLITUS PATIENTS WITH AND WITHOUT SCLEREDEMA BUSCHKE SKIN DISORDER

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Background: Scleredema adultorum of Buschke is a rare disorder characterized by non-pitting hardening of the skin around the neck, shoulders, occasionally the face and the trunk. The most frequent form of scleredema is associated with diabetes mellitus (DM). The histopathologic features of scleredema are characterized by thickened collagen bundles within the reticular dermis that are separated by mucopolysaccharides (mainly mucin) containing fenestrations.

Objectives: To compare clinical data of patients with Buschke-scleredema-DM to diabetic patients without skin involvement patients (Control-DM) with a focus on the late vascular and neurological complications.

Methods: Clinical data of 105 diabetic patients were investigated based on their medical histories and physical examinations. All subjects met the following inclusion criteria: each of their disease duration time of DM had to be more than three years. Twenty-eight patients with Scleredema-DM were collected (three of type 1 and 25 of type 2 diabetes, 19 female, nine male; their mean age (±SD) was 63.0±9.3 and mean DM-duration time was 17.9±9.6 years). Seventy-seven consecutive, age and DM-duration matched patients without skin involvement were investigated as controls (nine patients with type 1 and 68 with type 2 M, 50 female, 27 male, their mean age was 63.3±11.9 and mean DM-duration time was 17.4±10.7 years). For statistical analysis Pearson's Chi-squared, Fisher and Mann-Whitney U tests were used.

Results: In the medical history of the Scleredema-DM group stroke occurred more frequently (8 of 28 cases, 28.6%) compared to the Control-DM group (5/77, 6.5%, /$p<0.01$/). There were no significant differences in the occurrence of myocardial infarction (5/28, 17.9% vs. 10/77 cases, 13.0%), nephropathy (5/28, 17.9% vs. 10/77 cases, 13.0%), retinopathy (13/28 cases 46.4% vs. 28/77, 36.3%) and of peripheral neuropathy (21/28 patients, 75.0% vs. 49/77, 63.6%) respectively. Higher level of cholesterol and triglycerides was present in the Scleredema-DM group compared to the Control-DM cases (mean cholesterol was: 5.7±1.5 mmol/l vs. 4.6±1.2 mmol/l, /$p<0.01$/; triglyceride: 2.3±1.1 mmol/l vs. 1.84±1.6 mmol/l