was non-invasively assessed by Pulse pen device and AIx was evaluated by tonometry. Statistical analysis was done with SPSS v22 software, we calculated mean and standard deviation, for continuous variables we used Student t test, categorical variables were analyzed by using chi-square or Fisher's exact test. The correlation of AS and clinical variables was assessed with Spearman's correlation.

Results: Forty seven patients were included and compared with 39 healthy subjects; mean age of study group was 48±14. vs control group 47±13.7 (p=0.08) 93% were female. Prevalence of AS was 11% vs 3% p=0.039. AS was more frequent in limited systemic sclerosis sub-group and we found correlation with abnormal capillaroscopy, Rho 0.292 p=0.04.

Conclusions: Arterial stiffness is more prevalent in patients with limited systemic sclerosis and association with abnormal caillaroscopy suggest that both macro and microvascular damage is present in these patients and could explain the presence of early atherosclerosis and increased risk of cardiovascular disease.

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Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.3345

AB0642 THICKNESS OF THE INTIMA-MEDIA COMPLEX AND DOPPLER VELOCITY PARAMETERS IN SCLERODERMA PATIENTS

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Background: Systemic sclerosis (Ssc) is a chronic inflammatory autoimmune disease, that involves various tissues and organs, including the cardiovascular system. Ssc patients might suffer from a number of complications – including cardiovascular system diseases. Diagnostic imaging is an important tool in assessment of vascular lesions, and ultrasound (including Doppler ultrasound) is one of the most important examinations, which allow to scan for presence of atherotic lesions, assess the intima-media complex thickness as well as provide measurements of the blood flow parameters.

Objectives: The aim of study was to determine if there is any difference in the intima-media complex thickness as well as in blood flow parameters measured using Doppler ultrasound examination in scleroderma patients and the general population.

Methods: 35 patients, aged 19–75, with diagnosed systemic scleroderma were examined using a Doppler ultrasound examination. Thickness of intima-media complex (IMT) approximately 2 centimeters from the carotid bulb was assessed for both right and left common carotid artery (CCA). The standard parameters of blood flow were measured – including peak systolic velocity (PSV), end diastolic velocity (EDV), as well as resistive index (RI), pulsative index (PI) and standard deviation (SD) was measured in the common carotid arteries, internal carotid arteries (ICA) as well as in the vertebral arteries (VA).

Results: The mean IMT value in CCA was approximately 0.63mm (0.35 – 0.9mm).

The mean, minimal and maximal values measured in CCA equalled respectively: PSV – 68.7 cm/s (22.4–94 cm/s), EDV – 19,7 cm/s (4.7–30.35 cm/s), PI – 1.95 (0.41–2,09) and RI – 0.68 (0.28–0.81). In ICA the measured values were as follows: PSV – 68.4 cm/s (38.65–96.9 cm/s); EDV – 23.6 cm/s (9,05–38.6 cm/s), PI – 1.16 (0.76–1.71) and RI – 0.65 (0.37–0.79); in VA PSV – 46.5 cm/s (26.75–75.35 cm/s); EDV – 12.4 cm/s (6.1–22 cm/s), PI – 1.38 (0.6–2.28) and RI – 0.73 (0.34–1.33).

A positive correlation between the age of examined subjects and the IMT was found (p=0.002; R=0.49). Additionaly, a negative correlation between the IMT and the EDV was found (p=0.008, R=-0.44).

Conclusions: The mean thickness of intima-media complex in the examined group of SSc patients is within the values that were established for a healthy population, however a further investigation, including a control group study will allow to evaluate whether there is no correlation between systemic sclerosis and increased IMT.

A negative correlation between IMT and EDV was shown, which is an interesting finding, and could be confirmed in a control group study and on a larger group of patiens.

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Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.6296

AB0643 MALIGNANCY SCREENING IN AUTOIMMUNE MYOSITIS AMONGST AUSTRALIAN RHEUMATOLOGISTS

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Background: The association between cancer and autoimmune myositis is well established and has lead to the common practice of malignancy screening in asymptomatic individuals. The international literature advocates widely for cancer screening in autoimmune myositis however no consensus or guideline has been published to set forth a process for screening standardisation (1). Malignancy screening is a complicated topic and recommendations in favour of screening should in principle be based on a judicious assessment of the evidence in terms of the benefits, risks and costs. In inflammatory myositis there is currently insufficient evidence to support any recommendation with respect to cancer screening. In the absence of clinical guideline and quality evidence, our study aimed to establish the current trends in malignancy screening amongst Australian Rheumatologists.

Objectives: To explore the current trends in malignancy screening in autoimmune myositis amongst Australian Rheumatologists using an online questionnaire.

Methods: Research approval was granted by The Townsville Hospital. An invitation email containing the survey weblink was sent twice to 386 Australian Rheumatologists between August 2015 and August 2016. Voluntary participation and anonymity were guaranteed. The questionnaire contained a fixed set of multiple choice questions that requested data on respondent demographics, practice setting and screening preference, practice and concerns. Open entry comment was an option throughout the questionnaire. Fifty-eight Rheumatologists, 1 Immunologist and 1 Paediatric Rheumatologist responded (16% response rate). There were 3 survey dropouts. The data was pooled, coded and analysed using statistical software. All data was included in the analysis.

Results: Most respondents (N=58) were in private (67%) and/or public practice (68%), in practice for >10 years (70%), conducted cancer screening (93%) and were "very" or "somewhat" confident in their screening practice (90%). The majority (72%) performed cancer screening independent of patient characteristics. Determinants that triggered screening (in descending order of popularity) were: tobacco use (N=11), history of cancer (N=10), age >40 (N=7), cancer family history (N=7), age >50 (N=3) and age >60 (N=1). Most respondents indicated preference to order screening tests (in descending order of popularity): mammogram (81%); CT chest & abdomen (78%); myeloma screen (70%); chest x-ray (69%), serum PSA (67%), PAP smear (54%), colonoscope (44%), LDH (41%), pelvic USS (33%), gastroscope (33%), FOBT (33%), tumour markers (28%), CT neck (17%), nuclear bone scan (15%), PET CT (4%) & testicular USS (2%). Respondents (N=57) indicated that cancer screening was problematic due to a lack of clinical practice consensus & guideline (77%), test selection knowledge (37%) and knowledge regarding repeated screening (53%). The potential for harm in conducting screening was identified to be a problem by most respondents (62%).

Conclusions: The practice of malignancy screening in autoimmune myositis amongst Australian Rheumatologists is highly variable. Practice is driven by patient factors and clinician preferences. The cancer screening process is felt on several fronts to have inherent problems. Guideline, consensus and further research is needed in this area to address the challenges and evidence gap.

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Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.1148

AB0644 FINGERPRINT ABNORMALITIES IN SYSTEMIC SCLEROSIS: A SINGLE CENTER SURVEY FROM INDIA

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Background: Fingerprint [FP] abnormalities are known in patients with Systemic Sclerosis [SSc]. Little has been described about their frequency, systemic associations and social impact in literature.

Objectives: To study the fingerprint abnormalities in Systemic Sclerosis patients

Methods: Raynaud's phenomenon [RP] was taken as the inclusion criteria. Patients with SSc [limited LcSSc and diffuse DcSSc], SSc overlap with other Connective Tissue Diseases [CTDs] and other CTDs with RP were screened for FP abnormalities using a Standardization Testing and Quality Certification (STQC) Directorate certified biometric FP scanner. FP quality assessment was done by recording The National Institute of Standards and Technology [NIST] finger print image quality [NFIQ] scores[1]. NFIQ's 5 levels of quality are intended to be predictive of fingerprint matching. NFIQ=1 indicates high quality samples and NFIQ=5 indicates poor quality samples. Other associated systemic features of