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AB0680 ANALYSIS THE CAUSES AND COUNTERMEASURES OF IGNORING SWALLOWING DYSFUNCTION IN PATIENTS WITH POLYMYOSITIS AND DERMATOMYOSITIS

Y. Wen, Q. MinLi, L. Yan. *Department of Rheumatology, Third Affiliated Hospital of Sun Yat-sen University, Guangzhou, China*

Background: The patients with Polymyositis and Dermatomyositis always ignored swallowing dysfunction and most of them eventually had no enough knowledge of this. For this situation, to find out the reasons and take appropriate measures was necessary.
Objectives: To analyze the causes of ignoring swallowing dysfunction in patients with Polymyositis and Dermatomyositis and to explore the corresponding preventive measures.
Methods: The clinical data of 47 patients with Polymyositis and Dermatomyositis in hospital from September 2012 to December 2013 was analyzed retrospectively. The swallowing function was evaluated by the water swallow test, and the patients' knowledge of swallowing dysfunction was surveyed.
Results: Only 2 patients complained of choking during swallowing, with ignorance rate of 95.74%. Positive rate was 40.43% in water swallow test, of which grade II dysphagia proposition was 58%, III grade was 32%, IV grade was 10%. 100% of patients believed that sternal obstruction or dysphagia as swallowing dysfunction. 89.36% of patients didn't think drinking water with bucking as swallowing dysfunction.
Conclusions: The symptoms of limb weakness in patients with Polymyositis and Dermatomyositis may obscure the presence of dysphagia. In addition, the patients do not have enough knowledge about dysphagia that to neglect the swallowing dysfunction. To improve detection rate of swallowing dysfunction in patients with Polymyositis and Dermatomyositis, earching detailed history by listing dysphagia performance and providing water swallow test is necessary.
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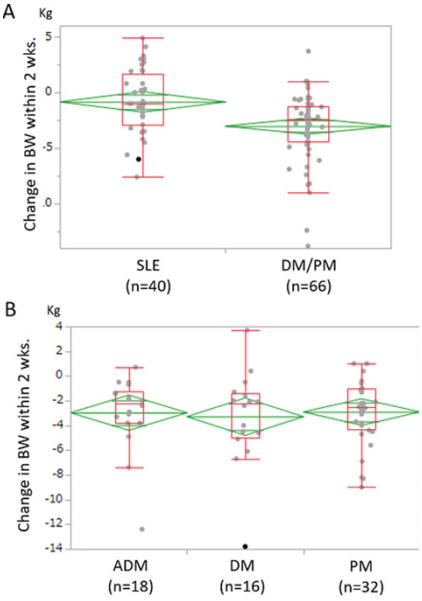
AB0681 HIDDEN GENERALIZED EDEMA IN INFLAMMATORY MYOPATHY; GENERALIZED EDEMA IS AN UNRECOGNIZED CLINICAL FEATURE OF MYOSITIS?

Y. Namiki[1], K. Kurasawa[2], A. Tanaka[2], R. Yamazaki[1], H. Okada[2], S. Arai[2], T. Owada[1], R. Maezawa[1], M. Arima[1]. *[1]Department of Rheumatology, Dokkyo Medical University, Mibu, Tochigi; [2]Department of Rheumatology, Dokkyo Medical University, Mibu, Tochigi, Japan*

Background: Dermatomyositis (DM)/ polymyoitis (PM) are systemic diseases characterized by muscle inflammation, which shows varieties of clinical symptoms and signs. We have experienced cases of DM/PM with generalized edema as reported previously by others (1). Moreover, we found that there were many myositis patients who lost their body weight (BW) after starting of high dose glucocorticoid (GC) therapy. Thus, we hypothesized that hidden generalized edema is a characteristic clinical feature of myositis.
Objectives: To determine whether generalized edema is a hidden clinical feature of myositis. If so, what myositis patients have the feature.
Methods: The study was a retrospective observation study. The subjects were consecutive 67 of DM/PM and 53 of SLE patients who diseases for the first time, admitted our department from April 2007 to September 2016 and received immunosuppressive therapy including over 30mg/day GC. The patients were excluded who had cardiogenic or nephrogenic edema or whose BW data was not available. To detect hidden generalized edema caused by inflammation, we examined the change in BW within 2 weeks after starting immunosuppressive therapy. The clinical features of DM/PM patients with/without BW change were examined through reviewing medical record.
Results: The included subjects were DM/PM 66 patients (M/F; 18/48 with a mean age of 59.4 y.) and SLE 40 patients (M/F;14/26 with a mean age of 49.8 y.). The body weight of DM/PM and SLE were 56.4±14.0 and 54.7±10.9 kg, respectively. Decrease in BW within 2weeks after starting the therapy were 3.02±2.99kg of DM/PM and 0.85±2.87 kg of SLE, which was larger in DM/PM compared to SLE (Fig A). The numbers of patients who lost BW more than 2kg within the 2 weeks were 42 in DM/PM (64%) and 14 in SLE (35%).
Serum albumin levels were slightly decreased by 0.18 g/ dl (0.06 to 0.30; 95% CI) in DM/PM, while no significant change was detected in SLE.
In myositis, change in BW was similar among DM, amyopathic DM (ADM) and PM (Fig.B). Moreover, no differences were found in the change of BW between patients with and without male sex, malignancy, interstitial pneumonia, anti-ARS Ab and anti-MDA5Ab. Additionally, between patients with and without BW loss more than 2kg, no differences were found in age, serum TP, Alb and CRP levels before and after treatment and prognosis.



Conclusions: DM/PM patients lose BW by immunosuppressive therapy including GC, which indicates the existence of hidden generalized edema that might be a characteristic clinical feature in inflammatory myopathy.
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AB0682 THE INCIDENCE RATE OF INFLAMMATORY MYOPATHIES IN SLOVENIA

Ž. Rotar[1], A. Hočevar[1], M. Krošel[1], S. Praprotnik[1], M. Tomšič[1,2]. *[1]Department of Rheumatology, University Medical Centre Ljubljana; [2]Faculty of Medicine, University of Ljubljana, Ljubljana, Slovenia*

Background: Annual incidence rates of inflammatory myopathies (IM) vary widely from 1.16–19.0 per 10^6 of adults.1 Our aim was to, for the first time, determine the incidence rate of IM in our population.
Objectives: To determine the incidence rate of IM in our population.
Methods: We retrospectively collected incident cases of IM from 1 January 2005 to 31 December 2016 at our department of rheumatology which is a part of an integrated secondary/tertiary university teaching hospital that is the only referral center for two well defined regions representing roughly a third of the national adult population. Tertiary cases are referred to our department from the entire country. We identified the cases by searching the electronic patient records (PRs) for ICD-10 codes M05, M33–35, M60, G73.7, G72.4. The paper and electronic PRs were scrutinized to assess clinical, laboratory and histopathological data. Descriptive statistics was used to describe our group of patients. The adult population size of the two regions served by our department was obtained from the national statistics institute database. The annual incidence rate for IM was then calculated.
Results: During the 12-year observation period we identified 117 new cases of IM from a well-defined adult white Caucasian population aged 18 or above. 38 cases were excluded from analyses since they were referred to our department from outside the two regions we serve on the secondary and tertiary level. Thus, we analyzed 79 cases of IM (63% female; median (IQR) age 67 (55–75) years; 44% ever smokers). The median time to diagnosis was 5 (IQR 3–12) months. We diagnosed 29% patients with dermatomyositis, 25% with anti-synthetase syndrome, 18% with polymyositis, 9% with statin induced necrotizing autoimmune myopathy, 9% with concomitant myositis as a part of connective tissue disease, 6% with paraneoplastic myositis, and 4% with undifferentiated myositis. The IM cases were most often diagnosed in the summer months (32.9%), followed