Using the DETECT PAH calculator, 14/ 41 (34.14%) were recommended for RH as follows: an initial value above 300 points in STEP 1 (with further indication of echocardiographic assessment) and subsequent STEP 2 over 35 were recorded. On the other hand, only 9/41 (21.95%) cases met the ultrasound criteria to be addressed to an invasive assessment when applying the ESC/ERS 2009 guidelines, the difference being statistically significant as compared to DETECT ($p<0.05$). PAH was finally confirmed in 8/41 (19.51%) cases, supporting our preliminary results in a pilot study on a limited number of patients.

Conclusions: DETECT is a reliable algorithm for early detection of PAH in patients with SSs, optimizing PAH screening and prompting the rheumatologist-cardiologist collaboration.

Disclosure of Interest: None declared

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FRI0384 A MINI-INVASIVE TECHNIQUE FOR HAEMODYNAMIC EVALUATION: NEW PERSPECTIVES FOR PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS IN SYSTEMIC SCLEROSIS (SSC)

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Background: PAH is one of the most severe complication and cause of mortality in SSs, with frequent late diagnosis as asymptomatic in its early stages. Right Heart catheterization (RHC) is the gold standard for PAH detection, though its invasive nature with high risk of procedure related complications stress the need for developing new screening methods to investigate it in early and possibly reversible stages. Pressure Recording Analytical Method (PRAM) was recently developed to obtain a minimally invasive haemodynamic monitoring, using an arterial line and proximal pulsosimetry. This analyses arterial blood pressure curve and measure both cardiac [Cardiac Index, Cardiac Contractility and Vascular Stiffness ratio (dP/dT)] and vascular [vascular stiffness, elastance], which can be usually obtained only through RHC.

Objectives: to evaluate the clinical usefulness of PRAM method in SSs patients and to identify haemodynamic parameters related to increased risk of developing PAH.

Methods: 40 ssc patients (35 women, mean age 60±9,3 years; mean disease duration 7.5 years) were evaluated with both RHC and PRAM on the same day. Mean pulmonary arterial pressure (mPAP), cardiac index (CI), systemic vascular resistances (SVR), right cardiac power index (RCPI, calculated with mPAPXCI_{PRAM}/451) were measured and concordance of the two methods was

Univariate Logistic Regression	Unadjusted OR	95% CI	p value
Dicrote Pressure	1.04	1.00–1.09	0.064
Arterial Elastance	3.16	0.70–14.24	0.134
Right Cardiac Power index	1.11	1.04–1.18	0.002
DLCO	0.94	0.90–0.99	0.021
Multivariate Logistic regression with backward stepwise analysis	Unadjusted OR	95% CI	p value
Right stroke work index	1.12	1.03–1.21	0.007
DLCO	0.94	0.87–1.01	0.072

assessed through Bland-Altman analysis. Systolic pulmonary arterial pressure and TAPSE from echocardiography, forced vital capacity, total lung capacity, both absolute and alveolar volume adjusted Carbone oxide lung diffusion (DLCO and DLCO/VA) from pulmonary function tests, blood tests parameters, nailfold videocapillaroscopy scleroderma patterns were recorded. Univariate and multivariate logistic regression analysis identified variables correlating with RHC-diagnosed PAH: a scoring system was then created, giving 1 point for value satisfying cut-off level.

Results: PRAM showed concordance with RHC estimate of CI and SVR within 95% interval confidence; 14 patients were diagnosed with PAH (mean age 64,4±9,3, mean disease duration 10.5 years, ISSc 61,5%). Multivariate logistic regression analysis showed DLCO (cut off value 47% obtained through ROC curve analysis, $p=0.004$) and RCPI (cut off value 0.12 Watt obtained through ROC curve analysis, $p<0.001$) as the most highly PAH-associated variables. When combining these two variables in the scoring system, patient with score=0 ($DLCO<47\%$ and $RCPI<0,12$ Watt), score=1 ($DLCO<47\%$ or $RCPI\geq0,12$ Watt) and score=2 ($DLCO<47\%$ and $RCPI\geq0,12$) were 0%, 21.4% and 78.6% of the PAH population respectively.

Conclusions: PRAM is comparable to RHC in detecting haemodynamic parameters such as SVR and CI. The scoring system combining DLCO and RCPI, obtained with non-invasive tools, could offer the possibility of detecting PAH patients with a high specificity.

Disclosure of Interest: None declared

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FRI0385 JOINT MANIFESTATIONS IN PATIENTS DIAGNOSED WITH IDIOPATHIC INFLAMMATORY MYOPATHY: MULTICENTER REGISTRY

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Background: Idiopathic inflammatory myopathies (IIM) comprise a heterogeneous group of autoimmune conditions. Joint involvement can be considered to be part of the IIM systemic manifestations, together with a possible gastrointestinal, cardiovascular and/ or pulmonary involvement. Although articular involvement in the IIM has been described as variable and non-specific with a chronic course it might be an early symptom of dermatomyositis in up to 30% of cases and in those patients with overlap syndromes.

Objectives: To evaluate and to identify joint manifestations in IIM patients.

Methods: We evaluated a cohort of 479 patients that included 12 hospitals in the Community of Madrid belonging to the IIM registry of the Society of Rheumatology of Madrid (SORCOM-REMICAM) with diagnosis from January 1980 to December 2014. All patients were diagnosed of IIM according to Bohan and Peter criteria (1). The presence of arthralgia and arthritis was considered. IIM were classified as dermatomyositis (primary and secondary dermatomyositis) (DM) and polymyositis (PM) including the rest of the patients (classification I). Also, IIM were classified (II) as primary polymyositis (PPM), primary dermatomyositis (PDM), overlap syndrome (OSd), juvenile myopathies (JM), cancer-associated myopathies (CAM), autoimmune necrotizing myopathy and inclusion body myositis (these were grouped as other myositis; OM).

Results: We found 70 (18%) patients with acute arthritis (<6 weeks), 74 (19%) patients with chronic arthritis (>6 weeks) and 245 (65%) patients without any joint manifestations. Using the Tanimoto et al. criteria (1), the presence of erosive arthritis was observed in 149/479 (38.3%) of the patients. When comparing the joint manifestations in the PM and DM groups ($n=250$, 52.2% vs. $n=229$, 47.8%) no statistically significant differences were observed. However, assessing joint manifestations according to classification II, we observed that the highest prevalence was found in the OSd group, followed by the PDM group ($p=0.0001$). The group with less joint manifestations was JM compared to OSd and PDM (Table 1).

Table 1: Joint manifestations in IIM according to classification II

Joint manifestations	Comparison between groups		Frequency	P
	OSd vs.	PPM PDM JM CAM OM	90% vs. 54% 90% vs. 71% 90% vs. 45% 90% vs. 49% 90% vs. 58%	
Arthralgias	OSd vs.	PPM PDM JM CAM	90% vs. 54% 90% vs. 71% 90% vs. 44% 90% vs. 49%	0,0001
Arthritis	OSd vs.	PPM JM CAM	90% vs. 34% 90% vs. 28% 90% vs. 33%	0,0001

Conclusions: The presence of joint manifestations associated with IIM in our cohort is higher compared to other studies described in the literature so far and