Anti-U1RNP was associated with muscle-skeletal manifestations (OR: 10.7 95% CI: 9.02–20.44) and with overlap syndromes (OR: 15.2 95% CI: 4.7–29.1). Pts with anti-Th/T0 and anti-RNA-polymerase III had lcSSc subtype. Vascular manifestations, oesophageal involvement and calcinosis cutis were the main manifestations, respectively. Table 1 shows detailed clinical manifestations and antibody profile.

Conclusions: In our cohort, ACA and anti-Scl70 were the commonest antibodies and were associated with lcSSc and dcSSc phenotype, respectively. ACA positivity conferred a higher risk of vascular disease and had a protective effect for ILD, while anti-Scl70 was associated with ILD.

Pts with anti-U1 RNP and anti-PM/Scl had mainly muscle-skeletal manifestations. This study confirms an association between immunological profile and clinical manifestations, reinforcing the importance of antibody profile and raising awareness for possible disease complications. Larger national studies would be desirable, specially for a better understanding of major organ involvement associated with least common antibodies.

Disclosure of Interest: None declared


**AB0728**

**NAILFOLD CAPILLAROSCOPY IN SYSTEMIC SCLEROSIS – SIX YEARS IN REVIEW**

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**Background:** Microvascular dysfunction is a dynamic process that is crucial in systemic sclerosis (SSc) pathogenesis. Nailfold capillaroscopy (NCP) is a rapid, non-invasive exam that illustrates the early capillary changes in SSc and monitor their evolution. It is extremely useful in clinical practice and has been recognised in 2013 ACR/EULAR classification criteria for SSc.

**Objectives:** Evaluate the prevalence and evolution of NCP scleroderma pattern in SSc patients and analyse possible associations with disease-phenotype.

**Methods:** NCP of SSc patients followed in our centre were reviewed; clinical and demographic features were collected. A descriptive analysis was performed and nonparametric tests compared patients with and without SSc pattern.

**Results:** In total, 70 out of 117 SSc patients had at least 1 NCP available during the last 6 years. Most of these patients (62.9%) had limited cutaneous SSc, 21.4% diffuse cutaneous SSc, 11.4% very early diagnosis SSc and 4.3% overlap syndromes; mean disease duration was 10.7±9.6 years.

At the moment of the first NCP, 46 patients (39.4%) had a scleroderma pattern, 12 (10.3%) had non-specific (NS) NCP abnormalities and 12 had a normal NCP. During the 6 years follow-up, NCP changed in 5 patients as illustrated in figure 1. However, none had concomitant development/worsening of other clinical manifestations.

At the end of the follow-up, 49 (70%) patients had a NCP scleroderma pattern. Early pattern was present in 13 (26.5%) patients, active pattern in 21 (42.9%), active/late pattern in 3 (6.1%) and late pattern in 12 (24.5%).

When comparing patients with and without scleroderma specific patterns (table 1), the presence of scleroderma pattern was associated with the presence of current/previous digital ulcers (OR 1.49 95% CI 1.17–1.92). However, this difference was not confirmed between the different scleroderma patterns.

Regarding, major organ involvement, although there were no statistical differences between both groups, patients with scleroderma pattern had a higher prevalence of oesophageal involvement.

**Abstract AB0728 – Table 1. Comparison between patients with and without scleroderma pattern**

<table>
<thead>
<tr>
<th></th>
<th>Non-scleroderma (n=10)</th>
<th>Scleroderma (n=11)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCP pattern</td>
<td>Normal</td>
<td>Non-specific</td>
<td>Early</td>
</tr>
<tr>
<td></td>
<td>72.7%</td>
<td>66.7%</td>
<td>71.1%</td>
</tr>
<tr>
<td>Age</td>
<td>55.3</td>
<td>66.7±5.7</td>
<td>58.2</td>
</tr>
<tr>
<td>Disease duration</td>
<td>9.4±6.6</td>
<td>8.3±3.4</td>
<td>7.6±6</td>
</tr>
<tr>
<td>Diffuse cutaneous disease</td>
<td>10%</td>
<td>27.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Disease activity</td>
<td>18.2%</td>
<td>32.6%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Digital ulcers</td>
<td>10%</td>
<td>0%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Pulmonary arterial hypertension</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Intestinal lung disease</td>
<td>10%</td>
<td>18.2%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Oesophageal involvement</td>
<td>40%</td>
<td>45.4%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Anticentromere +</td>
<td>50%</td>
<td>45.4%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Antitopoisomerase I +</td>
<td>20%</td>
<td>27.3%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

**Conclusion:** This study demonstrates how NCP can illustrate the dynamic vascular damage in SSc. In our data, a NCP scleroderma pattern was significantly associated with a higher number of digital ulcers and these patients had a higher percentage of oesophageal involvement.

In daily clinical practice, NCP is useful not only for corroborating SSc diagnosis, but also for monitoring endothelial injury and potential macrovascular/systemic damage. Although our sample is too small to demonstrate the associations between specific NCP alterations and internal organ involvement, some studies have already identify NCP patterns as predictive factors for organ damage.

Disclosure of Interest: None declared


**AB0729**

**QUALITY OF LIFE ASSESSMENT IN SYSTEMIC SCLEROSIS PATIENTS TREATED WITH AUTOLOGOUS STEM CELL TRANSPLANTATION: A LONGITUDINAL STUDY**

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**Background:** Autologous Hematopoietic Stem Cell Transplantation (AH SCT) has been explored as a therapeutic option for patients with systemic sclerosis (SSc) that do not respond to conventional treatment.

**Objectives:** To investigate changes in quality of life of severe and rapidly progressive SSc patients treated with AH SCT.

**Methods:** This is a longitudinal and comparative study. Patients were evaluated before (n=27) and at 6 (n=27) and 12 months (n=21) after AH SCT. The Generic Questionnaire for Evaluation of Quality of Life Medical Outcomes Study 36 Item Short-Form Health Survey (SF-36) was applied individually, face-to-face, under patient written consent. This questionnaire evaluates eight domains: physical functioning (PF), role-physical (RP), bodily pain (BP), general health (GH), social functioning (SF), vitality (VT), role-emotional (RE) and mental health (MH).

Results: Most participants were females (n=24), with mean age of 33 years (standard deviation, SD=10.33) and mean time from diagnosis of 34.4 months (SD=34.89). Before AH SCT, the mostly impaired aspects were: PF (mean=8.33, SD=18.34), and RP (mean=38.52, SD=21.56), while MH (mean=61.63, SD=15.46) and SF (mean=56.87, SD=27.17) were mostly preserved. At 6 and 12 months post-AH SCT, there was significant improvement of the SF-36 scores in the following domains: PF (6 months, p<0.01, 12 months, p<0.01); RP (6 months, p<0.01, 12 months, p<0.01); BP (6 months, p<0.01, 12 months, p<0.01); VT (6 months, p<0.01, 12 months, p<0.01); GH (6 months, p<0.01, 12 months, p<0.01). However, this difference was not confirmed between the different scleroderma patterns.

Regarding, major organ involvement, although there were no statistical differences between both groups, patients with scleroderma pattern had a higher prevalence of oesophageal involvement.

**Abstract AB0729 – Figure 1. Progression of nailfold capillaroscopy alterations during follow-up**

**Conclusions:** This study demonstrates how NCP can illustrate the dynamic vascular damage in SSc. In our data, a NCP scleroderma pattern was significantly associated with a higher number of digital ulcers and these patients had a higher percentage of oesophageal involvement.

Disclosure of Interest: None declared

AB0730  COMPARISON OF A SINGLE-CENTRE IDIOPATHIC INFLAMMATORY MYOPATHY COHORT FROM ARGENTINA WITH THE EUROMYOSITIS INTERNATIONAL REGISTRY

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Background: The idiopathic inflammatory myopathies (IIM) are rare systemic autoimmune diseases that affect the muscle and other organs. Traditionally, IIM encompasses polymyositis (PM) and dermatomyositis (DM), but progressively inclusion body myositis (IBM), Immune-mediated necrotising myopathy (IMNM), the anti-synthetase syndrome (ASS) and connective tissue diseases-overlaid myopathies (CTD-OM) have been recognised within the IIM spectrum.

Objectives: To compare the clinical characteristics and treatment in a IIM cohort from an Argentinian university hospital with the international IIM cohort EUROMYOSITIS

Methods: Descriptive, retrospective study. IIM patients defined by expert opinion followed in our centre between October 2007 and October 2017 were included. ASS was defined by the presence of arthritis, Raynaud’s phenomenon, mechanic hands, elevated CK, muscle weakness, interstitial lung disease and/or presence of anti-synthetase antibodies and, as in EUROMYOSITIS, patients with PM with positive anti-synthetase antibodies were reclassified as ASS. CTD-OM was defined as patients with IIM fulfilling classification criteria for other CTDs. Demographic data, accumulated clinical features, time interval between disease onset and diagnosis, IIM subtype, treatment and presence of neoplasm were evaluated.

Ethnicity was defined using the same classification as in EUROMYOSITIS.

Results: 58 patients were included: DM 24, PM 4, ASS 10, CTD-OM 20. 89.6% Hispanic, mean age 48.4±15.2 years, median time interval between disease onset and diagnosis 5 months (IQR 2–11 months), been higher in AAS (8.5 months, IQR 1.5–18.2 months). 6.89% (4/58) patients presented associated neoplasia, 3 with DM and 1 with CTD-OM. Table 1 shows the demographic and clinical features of our IIM cohort and EUROMYOSITIS. Table 2 shows treatments received in our cohort and EUROMYOSITIS.

Conclusions: DM was the most frequent IIM subtype in both cohorts. In our group, CTD-OM was second and ASS was third. Muscle weakness was found less frequently in our DM and AAS than reported in EUROMYOSITIS. However, calcinosis was more frequent. This could be explained by our mostly Hispanic population and/or by frequent Systemic Sclerosis overlap in our patients. It’s important to remark that the ethnic variety defined as Hispanic in EUROMYOSITIS has a complex composition in Latin America, due to interbreeding.

No difference was found in terms of most frequent treatments between both cohorts. However, use of IVlg was more frequent in our patients.

To our knowledge, this is the first comparative report of an Argentinian single-centre IIM cohort and an international multi-centre cohort

Disclosure of Interest: None declared


AB0731  TREATMENT ALGORITHMS FOR SYSTEMIC SCLEROSIS ACCORDING TO EXPERTS

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Background: Treatment for many aspects of systemic sclerosis (SSc) lacks agreement.

Objectives: To generate SSc treatment algorithms endorsed by high percentage of SSc experts.

Methods: Experts from the Scleroderma Clinical Trials Consortium and the Canadian Scleroderma Research group (n=170) were asked whether they agreed with SSc algorithms (from 20121). A further 2 consensus rounds refined agreement; 62 (36%), 54 and 48 experts completed surveys.

Results: For scleroderma renal crisis (SRC), 82% of the experts agreed (1st line ACEi, 2nd and 3rd adding CCB or ARB). Pulmonary arterial hypertension (PAH) had 61% agreement. For mild PAH, PDE5i, then endothelin receptor antagonists plus PDE5i, then prostanoids; while for severe PAH prostanoids were first-line. Raynauds’ phenomenon (RP) had 78% of agreement [mild (1st CB1, 2nd adding PDE5i, 3rd ARB or switching to another CB1, 4th prostanoids), severe (1st CB1, 2nd adding PDE5i, 3rd ERA, 4th prostanoids)]. Digital ulcer (DU) treatment had 69% agreement (1st CB1, 2nd PDE5i). Interstitial lung disease (ILD) had 65% agreement including induction (Myophenolate mofetil (MMF) then intravenous cyclophosphamide then rituximab) and maintenance (1st line MMF). Skin involvement had 71% agreement. For a modified Rodnan skin score (mRSS) of 24 1st MTX, 2nd MMF; and for mRSS 32 1st MMF, 2nd MTX, 3rd intravenous cyclophosphamide (CYP), 4th hematopoietic stem cell transplantation. For inflammatory arthritis 79% agreed with 1st MTX, 2nd low dose glucocorticoids, 3rd hydroxychloroquine, 4th rituximab or tocilizumab. Cardiac and gastrointestinal algorithms had >75% agreement. The evolution of the agreement rates is shown in table 1:

Disclosure of Interest: A. Fernandez-Codina Grant/research support from: Spanish Federation for Internal Medicine; Ontario Scleroderma Association, K. Walker: None declared, J. Pope Grant/research support from; ABVie, Actelion, Amgen, BMS, GSK, Lilly, Merck, Novartis, Pfizer, Roche, Sandoz, Sanofi, UCB