patients showed lower score in general health domain than RA patients (age and sex-adjusted scores, 41.4 ± 1.8 vs 51.3 ± 1.8 , $p < 0.001$). Moreover, SSc patients reported remarkably lower scores of EQ-5D-3L index scores than all comparative rheumatic disease groups (RA, SLE, SJS) ($p < 0.001$). HRQoL of patients with SSc was associated with HAQ-DI and SSc HAQ-DI.

Abstract AB0753 – Table 1. Comparisons of the SF-36, SF-6D and EQ-5D-3L, adjusted by age and sex in study subjects.

	Group					
	SSc (N=120)	RA (N=120)	SLE (N=120)	SJS (N=120)	Control (N=600)	ANOVA P ²
Physical function	70.5 (2.2)	70.3 (2.2)	68.2 (2.2)	73.9 (2.2)	82.4 (1.0)	<0.001
Role-physical	67.8 (2.3)	70.5 (2.3)	65.8 (2.3)	68.6 (2.4)	86.5 (1.1)	<0.001
Bodily pain	61.1 (2.2)	61.4 (2.2)	66.1 (2.2)	63.1 (2.3)	81.4 (1.0)	<0.001
General health	41.4 (1.1) ¹	51.3 (1.1)	44.2 (1.1)	45.8 (1.1)	61.9 (0.8)	<0.001
Vitality	51.2 (1.9)	51.8 (1.9)	49.7 (1.9)	45.8 (1.9)	64.6 (0.9)	<0.001
Social function	72.4 (2.1)	77.8 (2.1)	74.6 (2.1)	71.3 (2.1)	87.3 (1.0)	<0.001
Role-emotional	68.4 (2.3)	77.2 (2.3)	72.7 (2.3)	69.6 (2.4)	87.7 (1.1)	<0.001
Mental health	61.3 (1.1) ²	71.7 (1.1)	67.2 (1.1)	63.7 (1.1)	75.2 (0.8)	<0.001
Physical component score	44.6 (0.8)	45.3 (0.8)	44.3 (0.8)	46.9 (0.8)	51.6 (0.4)	<0.001
Mental component score	43.0 (0.9) ³	48.9 (0.9)	46.6 (0.9)	44.2 (0.9)	50.8 (0.4)	<0.001
SF-6D	0.70 (0.01)	0.73 (0.01)	0.72 (0.01)	0.71 (0.01)	0.79 (0.00)	<0.001
EQ-5D-3L index score	0.75 (0.01) ³	0.81 (0.01)	0.82 (0.01)	0.83 (0.01)	0.90 (0.01)	<0.001
EQ-VAS	63.98 (1.55)	69.95 (1.56)	67.49 (1.55)	64.84 (1.58)	77.88 (0.72)	<0.001

Conclusions: HRQoL of patients with systemic autoimmune diseases is significantly worse and affects all health domains in comparison to healthy controls. Patients with SSc have poorer HRQoL than patients with other rheumatic diseases. Specifically, SSc patients have more impaired mental health than RA patients, and the perception of an individual's general health is also poor compared to RA.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2264

AB0754

LONG-TERM FOLLOW-UP OF 214 PRIMARY RAYNAUD'S PHENOMENON PATIENTS

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Background: Raynaud's phenomenon (RP) is frequently associated with the presence of scleroderma or other connective tissue diseases (CTD). Identify the presence of secondary RP is important to perform an adequate therapeutic management and to achieve the early control of these patients. Nailfold capillaroscopy is safe, economic, and relatively easy to perform and has proven to be useful in identifying patients with secondary RP.

Objectives: To assess a long-term follow-up primary RP patient's series.

Methods: Retrospective observational study of a wide and unselected series of patients diagnosed as primary RP from a single university hospital from January 2012 to August 2017. Patients were classified as primary RP after the presence of CTD at the onset was excluded.

Results: We studied 214 patients (85.98% were female), with a mean age of 47.6 ± 16.7 years (range 15–88). After a mean follow-up period of 46.4 ± 23.3 months, 8 patients were diagnosed of a CTD (2 Scleroderma/Systemic sclerosis, 3 Systemic Lupus Erythematosus, 1 Rheumatoid arthritis and 2 Sjogren's syndrome). The remaining 206 patients continued classified as primary RP.

The main capillaroscopic patterns observed were: Normal ($n=157$), unspecific ($n=49$), scleroderma pattern ($n=2$) and suggestive of other rheumatic diseases pattern ($n=6$).

All patients who developed a CTD during the follow-up, showed changes in successive nailfold capillaroscopic examinations. 20 of 206 patients who remained primary RP showed minor changes at successive nailfold capillaroscopy. The main capillaroscopic changes detected on this group were: presence of capillary tortuosity ($n=4$), presence of a decreased capillary density² and the presence of capillary bleeding ($n=16$).

Antinuclear antibodies (ANA) were positive at the onset in 34 patients and after follow-up in 39 patients.

Conclusions: After a mean follow-up period next to four years, most of our primary RP patients remained free of CTD. A minority of our patients showed changes at nailfold capillaroscopy exam or positivity of ANA.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6318

AB0755

SKIN SCORE PROGRESSION AFTER DISCONTINUATION OF MYCOPHENOLATE TREATMENT IN SYSTEMIC SCLEROSIS PATIENTS

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Background: Rapid progressive skin involvement in diffuse Systemic Sclerosis (rp-dcSSc) is associated with higher mortality and internal organ involvement. Treatment with Mycophenolate Mofetil (MMF) has been shown to halt the progression of the disease. However, the optimal duration of therapy is unknown and has not been studied. We follow up a known cohort of rp-dcSSc patients treated with MMF after discontinuation of therapy.

Objectives: To describe the progression of skin involvement in rp-dcSSc patients after discontinuation of MMF

Methods: Twenty-five previously untreated consecutive patients with recent-onset (<24 mo) rp-dcSSc received MMF as the only disease-modifying therapy. Their Modified Rodnan skin score (mRSS) and Pulmonary function tests were followed after discontinuation of MMF after 2 years of treatment. Patients were followed up every 3–6 months. Therapy was re-initiated if their mRSS increased more than 20% or worsening respiratory symptoms with progression of restrictive lung disease were reported.

Results: Six patients lost follow up after terminating the open label trial with MMF. From the 19 patients followed up after MMF discontinuation, 26.3%⁵ required to resume MMF. All these patients required to resume MMF within 6 months after discontinuation. All of them presented increase in mRSS. Two of them (10.5%) presented respiratory symptoms associated with restriction pattern at PFTs. Skin score returned to baseline in 80% of the patients after resuming therapy.

Abstract AB0755 – Figure 1. mRSS after MMF discontinuation.

Conclusions: Recurrent skin progression occurs in up to 26.3% of patients with rp-dcSSc after discontinuation of 2 years of MMF, requiring longer term immunosuppression. In this group, all patients presented active skin disease recurrence within 6 months of treatment discontinuation. Ergo, slow decrease of MMF dose over time and very close follow up is recommended in patients with rp-dcSSc discontinuing MMF even after a prolonged period of time. In addition, these findings support the therapeutic effect of MMF in rp-dcSSc.