Abstract AB0772 – Figure 1

Conclusions: In our study, we observed the significant variation in ABI in one year, this may be due to the fact that this measurement has a high sensitivity for the detection of early peripheral arterial disease, in those patients who have not manifested signs and symptoms of arterial disease due to more evolved time of evolution.

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AB0773 INTERVENTIONS FOR MORPHEA: A COCHRANE SYSTEMATIC REVIEW

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Background: Morphea is a chronic inflammatory and fibrosing disorder usually limited to the skin and underlying tissues. It is an immune-mediated disease in which excess synthesis and deposition of collagen in the skin and connective tissues results in hardened cutaneous areas.

Objectives: To assess the effectiveness and safety of treatments for individuals with any form of morphea.

Methods: We searched the following databases up to March 2017: the Cochrane Skin Specialised Register, CENTRAL, MEDLINE, Embase, LILACS, and five trials registry databases. We checked the reference lists of included studies for further references to relevant randomised controlled trials.

We included randomised controlled trials assessing the effects of topical, intralesional, or systemic treatments for morphea (isolated or combined).

Two authors independently assessed study eligibility, extracted data, assessed risk of bias and performed analyses. A third author settled any disagreements.

Results: We included 13 trials, totalling 426 participants. There were both juvenile and adult participants (mostly women). The majority had limited morphea, followed by linear morphea.

The studies evaluated heterogeneous therapies for morphea, covering a wide range of comparisons. Thus, we could not pool data from the studies in a meta-analysis. Six studies investigated topical medications, two evaluated intralesional medications, and five investigated systemic medications.

Regarding our primary outcome global improvement of disease activity or damage:

- The number of juvenile participants with a significant clinical response was higher with oral methotrexate plus oral prednisone than with placebo plus oral prednisone (RR 2.31, 95% CI 1.20 to 4.45, after the 12 month treatment; NNT 3; low-certainty evidence);

- We are uncertain whether fractional carbon dioxide laser and the combination of acupuncture, hot herbal compress and moxibustion plus Centella triterpenes tablets and vitamin E may reduce this outcome, as the certainty of the evidence was very low;

- We found no differences in the MSS score between the following comparisons (very low-certainty evidence): oral hydroxychloroquine plus topical corticosteroid versus oral methotrexate plus folic acid and topical corticosteroid; and medium-

dose ultraviolet A-1 (50 J/cm²) versus low-dose ultraviolet A-1 (20 J/cm²) phototherapy versus narrowband UVB.

We are uncertain regarding adverse effects of interventions as the certainty of the evidence was very low. However, participants reported marked pain and pruritus during fractional carbon dioxide laser therapy, and had mild tanning after ultraviolet A-1 phototherapy.

Conclusions: There is a lack of high-certainty evidence for the treatment of morphea, and the effectiveness and safety of the interventions are unclear. Low-certainty evidence supports the effectiveness of oral methotrexate plus oral prednisone for treating juvenile morphea. More studies are necessary to assess the effectiveness and safety of interventions for morphea.

Acknowledgements: This abstract is based on a draft and pre-peer review version of a Cochrane Review. Upon completion and approval, the final version is expected to be published in the *Cochrane Database of Systematic Reviews* (www.cochranelibrary.com).

Disclosure of Interest: None declared

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AB0774 IMPACT OF STANDARDISED EDUCATION PROGRAM ON THE ACCURACY OF MODIFIED RODNAN SKIN SCORING IN PATIENTS WITH SYSTEMIC SCLEROSIS

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Background: Modified Rodnan skin score (mRSS) has been used as not only a primary outcome in many clinical trials, but also as an important surrogate marker of disease activity in patients with systemic sclerosis (SSc). Therefore, establishment of well-organised training program of mRSS is essential for the proper management of patients. Recently, Scleroderma Clinical Trials Consortium and the World Scleroderma Foundation published the recommendation for 2-phase mRSS training and emphasised assessing scoring accuracy after the training.

Objectives: To investigate the effect of modified Rodnan skin scoring (mRSS) education on improving its accuracy

Methods: Ten rheumatologists (6 professors and 4 fellows) received an education program composed of video education and live demonstration by master instructor (Marco Matucci-Cerinic) at (Seoul in June, 2017). Physicians measured mRSS of 8 patients with SSc 1) before the education, 2) after the video education and 3) after live demonstration without any clinical information of the patients. Accuracy of skin scoring was estimated by the difference from the pre-defined gold-standard score measured by master instructor. Change in accuracy of mRSS during the education course was analysed using linear mixed model. Intra-observer reliability of the mRSS and its change was assessed by intraclass correlation coefficient (ICC).

Abstract AB0774 – Table 1. Multivariable analysis indicating effect of the education program on the accuracy of modified Rodnan skin scoring

	Regression coefficient ^a	95% CI	P value
Education	Reference ^b	NA	0.012 ^c
Before education			
After video education (vs. before education)	-3.91	-7.12 to -0.68	0.013
After live demonstration (vs. before education)	-5.14	-8.50 to -1.37	0.008
Education x examiner's status (professor vs. fellow)			<0.001 ^d
Education x examiner's status (professor vs. fellow)	-5.35	-8.47 to -2.23	0.001
Professor vs. fellow before education	1.79	-1.33 to 4.91	0.258
Professor vs. fellow after live demonstration	4.46	1.34 to 7.58	0.005
Education x disease type (diffuse type vs. limited type)			0.029 ^e
Diffuse vs. limited before education	-3.07	-6.55 to 0.20	0.066
Diffuse vs. limited after video education	1.60	-1.68 to 4.88	0.336
Diffuse vs. limited after live demonstration	0.65	-2.62 to 3.93	0.693
Disease duration ^f	0.52	-0.11 to 0.75	0.148
Gold-standard skin score ^g	-0.60	-0.86 to -0.35	<0.001
Professor's gender ^h (male vs. female)	-0.47	-3.04 to 2.10	0.716

^a, Dependent variable = (Examiner's skin score – gold-standard skin score). Regression coefficient indicates the difference in dependent variable as compared with reference.

^b, This clinical factor consistently influence the dependent variable irrespective of education course.

^c, indicates P value for type 3 fixed effect

^d, (Physician's skin score – gold-standard skin score) (95% CI) was estimated as 7.66 (6.03 to 9.29) before the education.

Results: The number of SSc patients ever experienced by each physician was significantly higher in the professors than fellows but the number of mRSS ever performed was comparable between the two groups. Median (IQR) skin score