rays shows only 3,59% of patients with erosions, 38,6% were positive for Osteoarthritis (OA), and 58,6% of patients without erosions. From patients without erosions, 36% were confirmed for RA and 13,4% for OA by US; on the other hand 37% was confirmed for RA and 20% for OA by MRI. A total of 94 patients (26,1%) had a final diagnosis of seronegative RA, while (261) patients 72,5% were confirmed for Osteoarthritis,⁵ 1,4% were classified in other arthropathies.

Conclusions: According with our findings the screening by imagenology is a useful tool with low cost to make a differential diagnosis of seronegative RA and other arthropathies. In order to improves outcomes through well-defined treatments and to save high cost treatments for pathologies with more precise diagnoses.

Disclosure of Interest: None declared

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AB1210

ANKLE BRACHIAL INDEX FOR THE DIAGNOSIS OF SUBCLINICAL ATHEROSCLEROSIS USING CAROTID INTIMA MEDIA THICKNESS IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENT IN SANGLAH HOSPITAL

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Background: Atherosclerosis and its complications in Systemic Lupus Erythematosus (SLE) patients occurred more rapidly than the general population. Early detection of atherosclerosis is currently a challenge for clinicians. Angiography as a gold standard diagnosis of atherosclerosis is invasive, has a limitation. The surrogate marker carotid intima media thickness (CIMT) examination with B-mode ultrasonography has been used widely and validated. The limitation of this examination is operator dependence. Ankle brachial index (ABI) examination is simpler, cheaper, objective and widely available and is expected to be used for the diagnosis of subclinical atherosclerosis.

Objectives: to determine the sensitivity, specificity, positive predictive value and negative predictive values of the ABI to establish the diagnosis of subclinical atherosclerosis in SLE patients.

Methods: A cross sectional study was enrolling 56 subjects and was conducted from September 2016 to July 2017 at Sanglah Hospital, Denpasar, Bali, Indonesia. We used 2 × 2 cross table to determine the sensitivity, specificity, positive predictive value and negative predictive values of ABI to establish the diagnosis of subclinical atherosclerosis.

Results: Of the 56 samples, 48 people (85.7%) were female. The area under ROC curve was 0708 (70.8%), p=0041. ABI examination to diagnose subclinical atherosclerosis in patients with SLE with a cutoff value of 0.95 has a sensitivity of 70%, specificity of 76.1%, 38.9% positive predictive value, and negative predictive value of 92.1%. The best cut-off value of ABI as a diagnostic tool for subclinical atherosclerosis in SLE patients is <0.95.

Conclusions: Examination with ABI can be considered as an alternative diagnostic when CIMT is not available. The diagnostic value of ABI is reliable enough for screening and diagnostic confirmation of subclinical atherosclerosis in patients with SLE.

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AB1211

UTILITY OF PET/CT FOR THE DIAGNOSIS AND DISEASE MANAGEMENT: A STUDY OF 88 PATIENTS FROM AN AUTOIMMUNE DISEASES HOSPITAL UNIT IN A 2-YEAR PERIOD

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Background: 18F-Fluorodeoxyglucose Positron Emission Tomography/Computed Tomography (18F-FDG PET/CT) is a non-invasive imaging technique commonly used in clinical oncology. 18 F-FDG accumulation is recognised as useful for diagnosing and monitoring the response to therapy in patients with some inflammatory disorders, but the role of the PET/TC in the management of these diseases is debated.

Objectives: The aim of this study was to investigate the role of 18F-FDG PET/CT in the diagnosis of the disease and assessing disease activity in an autoimmune diseases unit, and to evaluate if the results of this image technique imply a change in clinical management.

Methods: We retrospectively reviewed all 18F-FDG PET/CT requested since August 2015 to August 2017 by our unit. Data collected were: patient demographics, reason for PET request, PET results and change in therapy.

Results: PET/CT were performed in 88 patients and were positive in 68 (77.3%) cases. Patients (49 women/39 men) had a mean age of 58,1±15,7 years (range, 27–92 years). The clinical diagnosis at the moment of ordering the PET/CT were: sarcoidosis (n=45), large-vessel vasculitis (LVV) (n=16), immunoglobulin G4-related disease (IgG4-RD) (n=9), collagen-vascular diseases (CVD) (n=7), mesenteric panniculitis (n=4), myopathy (n=4), polymyalgia rheumatica (PMR) (n=2) and ANCA-associated vasculitis (n=1). (See table 1).

Abstract AB1211 – Table 1

	Sarcoidosis	LVV	IgG4-RD	CVD	Mesenteric panniculitis	myopathy	PMR
n	45	16	9	7	4	4	2
women	27 (60%)	13 (81,2%)	1 (11,1%)	4 (57,1%)	1 (25%)	2 (50%)	1 (50%)
age	50,9 (27–83)	72,5 (29–92)	63,7 (48–80)	53 (30–80)	60,5	66,2	72,5
PET to the diagnosis	9 (20%)	2 (12,5%)	1 (11,1%)	3 (42,9%)	3 (75%)	2 (50%)	2 (100%)
PET to disease activity	36 (80%)	14 (87,5%)	8 (88,9%)	4 (57,1%)	1 (25%)	2 (50%)	0
Positive PET/TC	36 (80%)	11 (68,7%)	6 (66,7%)	6 (85,7%)	3 (75%)	3 (75%)	2 (100%)
Change of therapy	31 (68,9%)	11 (68,7%)	6 (66,7%)	7 (100%)	2 (50%)	3 (75%)	2 (100%)

PET results supported a change in therapeutic management in 71.6% of the cases. In the group of sarcoidosis there was a change in treatment in 68.9% of cases. PET/TC revealed extrapulmonary manifestations in 57.8%. All patients with extracranial manifestations of giant cell arteritis (GCA) showed uptake in PET/TC. That result supported the clinical diagnosis, although negative temporal artery biopsy. PET was useful in the diagnosis and treatment of IgG4-RD in 66.7% of cases. PET scan did not find malignancy in inflammatory myopathies nor mesenteric panniculitis.

Conclusions: PET/TC is an increasingly utilised in our patients with inflammatory disorders as a support for the diagnosis and management. PET/TC detection extrapulmonary sarcoidosis may have therapeutic and prognostic clinical implications. PET may be useful in patients with GCA suspicion with negative biopsy and extracranial symptoms. More studies will be necessary to establish the real role of PET/TC in autoimmune and inflammatory diseases.

Disclosure of Interest: None declared

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AB1212

ANALYTICAL VALIDATION OF AN INTERFERON-INDUCIBLE GENE EXPRESSION KIT AS A POTENTIAL DIAGNOSTIC TEST FOR ANIFROLUMAB

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Background: Anifrolumab, a fully human monoclonal antibody that binds to the type I interferon receptor, is in Phase III development for moderate to severe systemic lupus erythematosus (SLE). Patients with greater interferon-inducible gene signatures (IFNGS) have enhanced response to anifrolumab treatment.¹