SAFETY AND EFFECTIVENESS OF COSMETIC MINIMALY INVASIVE PROCEDURES AMONG PATIENTS WITH SYSTEMIC AUTOIMMUNE DISEASE

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Background: Noninvasive or minimally invasive cosmetic dermatologic procedures are considered safe with low rate of reported adverse events. However, reliable prevalence data regarding adverse event of such cosmetic procedures among patients with systemic autoimmune diseases are insufficient.

Objectives: To assess the occurrence of adverse events and disease exacerbation associated with noninvasive or minimally invasive cosmetic dermatologic procedures, including those involving hyaluronic acid fillers, botulinum toxins and laser application among patients with systemic autoimmune diseases.

Methods: Consecutive cases of patients suffering from autoimmune diseases and attending the rheumatology clinic for regular follow-ups, were asked about receiving cosmetic procedures during the last two years. Medical history, including of topical and laboratory signs of disease exacerbation after the date of the procedure, was retrospectively obtained from medical files of the patients included in the study. Patients were also asked about subjective disease exacerbation and local adverse events after the procedure.

Results: During the three months of study period, 148 patients were inquired. Nineteen patients (99% females) underwent 23 cosmetic procedures in total. Thirty-nine percent had Rheumatoid arthritis (RA), 39% had Ankylosing spondylitis (AS) and 22% had other systemic connective tissue disease. Sixty seven percent were treated by Disease-modifying antirheumatic drugs (DMARDs), 28% by Biologic treatment and 5% did not receive any specific treatment. All patients were in remission during the cosmetic procedures. Forty three and a half percent of patients underwent hyaluronic acid injection, 21.7% botulinum toxin injection, 21.7% laser application, 8.7% mesotherapy and 4.3% silicon injection. None of the patients suffered from subjective disease exacerbation after the procedure.

None in antibody titer and level of acute phase reactants (C-reactive protein and erythrocyte sedimentation rate) were noticed. Two patients (10.5%) experienced local oedema after filler injections. Both patients received Hydroxychloroquine (one patient with RA and one with AS).

Conclusions: Our results suggest that noninvasive or minimally invasive cosmetic dermatologic procedures, including energy, neurotoxin, and filler procedures, may be safe among rheumatological patients, and do not cause autoimmune systemic disease exacerbation when performed in periods of remission. Hydroxychloroquine may predispose to a higher occurrence rate of local site injection adverse events. Further studies are desired to investigate this phenomenon.

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IS THE RADIOGRAPHIC DAMAGE A RISK FACTOR FOR NEUROPATHIC PAIN IN RHEUMATOID ARTHRITIS?

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Background: Features suggestive of neuropathic pain (NP) have been identified in patients with Rheumatoid Arthritis (RA) patients. The structural damage assessed on radiographs is a direct consequence and reflection of cumulative disease activity and its association with NP has not been studied in RA

Objectives: To determine whether existence and intensity of NP is associated with radiographic damage in RA patients.

Methods: Cross-sectional study was performed with RA patients followed at our Rheumatology department. Patients with diagnosed neuropathy or non-RA risk factors for NP were excluded. Selected patients were evaluated in a medical visit. Two questionnaires were applied to assess NP: the Leeds Assessment of Neuropathic Symptoms (LANSS) and the painDETECT (PDQ). Wrist, hands and feet radiographic studies from the previous 12 months before were classified according to the modified van der Heijde Sharp’s method by one trained reader, blinded for patient clinical variables and treatment allocation. Correlation studies (spair correlation coefficient analysis) and univariate and multivariable logistic regression were performed. Significance level was set as <0.05

Results: Ninety one RA patients were included. Seventy seven (77%) were women, with a mean age of 55.6±10.8 years and median disease duration of 12 years; 84% patients were seropositive for Rheumatoid Factor and/or ACPA; 85 (93%) were treated with conventional synthetic Disease-Modifying Antirheumatic Drugs (DMARDs) and 41% with a biological DMARD (bDMARDs). The mean DAS28 4.115±0.77 and the mean HAQ score was 1.04±0.6. The median joint erosion score (JE) was 23±143 and the median joint space narrowing (JN) was 46. The 40-50% (46%) patients had LANSS NP (>12), 29% had a possible/likely NP in the PDQ (>12), and 13% had likely NP in the PDQ (>18). JN and global scores had a negative weak correlation with LANSS (<r=0.21 and <r=0.25, respectively, p<0.05) and JN correlated with PDQ (r=-0.23, p<0.03). No significant correlations were observed with JE. Disease duration significantly correlated with all the radiographic scores (r=0.48 for GS, r=0.43 for JN, r=0.44 for JE, p<0.05) and negatively correlated with LANSS (r=-0.28, p=0.01). Lower median GS values were observed in LANSS positive group (62 vs 79, p=0.01). Patients under bDMARDs had significant higher median GS (80 vs 61, p<0.03) but also higher disease duration (14 vs 10, p=0.01). No statistically significant differences were observed for other variables. Disease duration was a negative predictor of LANSS NP (OR: 0.98, p<0.03). JN was inversely associated with LANSS NP (OR: 0.978, p=0.02) and remained significant after adjustments for bDMARDs treatment, but not for disease duration. JN was also a negative predictor of PDQ likely NP and remained significant after adjustment for bDMARDs (OR: 0.979, p=0.03), but not for disease duration.

Conclusions: In this cohort, JN score had a weak negative association with NP. Higher structural damage and disease duration do not seem to increase the risk of non-nociceptive RA pain. Further studies are needed to confirm these results.

REFERENCES:

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