PGA and physician global health assessments were compared using Wilcoxon rank-sum tests.

Results: 16 parents and 31 patients completed the assessments (table 1). There was a moderate correlation between PGA and JADAS-71 ($r=0.503$, $p<0.001$), and PGA and physician global health assessments ($r=0.503$, $p=0.002$). There was a stronger correlation between physician global health assessments and JADAS-71. PGA median scores and IQRs appeared to be higher among patients with Medicaid insurance, non-white race, and Hispanic ethnicity, with the greatest difference seen in the category of race (Table 2). There were no differences between patient and physician assessments across all groups except among patients with Medicaid (difference median=-1.25) and Hispanic patients (difference median=2).

Abstract AB1377 – Table 1. Patient Characteristics

	Patients and Parents (n=47)	Patients (n=31)	Parents (n=16)
Age, years (median, IQ range)	12.4 [8.6–15.0]	14.2 [12.4–15.8]	4.3 [3.3–9.0]
Male Gender	17 (36.2%)	14 (45.2%)	3 (18.8%)
Race			
Caucasian/White	38 (80.9%)	24 (77.4%)	14 (87.5%)
Asian	3 (6.4%)	3 (9.7%)	0 (0.0%)
Other	6 (12.7%)	4 (12.9%)	2 (12.5%)
Hispanic Ethnicity	8 (17.0%)	5 (16.1%)	3 (18.8%)
Insurance			
Medicaid	8 (17.0%)	4 (12.9%)	4 (25.0%)
Private	39 (83.0%)	27 (87.1%)	12 (75.0%)

Abstract AB1377 – Table 2. Comparison of Patient Global Assessments by age, sex, insurance status, race and ethnicity

	Patient global median [IQR]	P-value
Age	2 [0–5]	0.892
Patient completed	2 [0.05–4.5]	
Parent completed		
Sex	2 [0–5]	0.679
Male	2 [0–4]	
Female		
Insurance	2.5 [1, 5]	0.313
Medicaid	2 [0–4]	
Private		
Race	1.5 [0–4]	0.266
White	4 [2–5]	
Non-white		
Ethnicity	2.5 [2.5–5]	0.134
Hispanic	1 [0–4]	
Non-Hispanic		

Conclusions: Our results demonstrate that physician global health assessment had a stronger correlation with standard disease activity measures than the PGA. These scores were higher in patients who were non-White race, Hispanic, and had Medicaid insurance; however, these were not statistically significant. These data indicate that the PGA is fairly stable across groups, and can be used reliably for disease monitoring.

Disclosure of Interest: None declared

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AB1378 CLINICAL COMPARISON OF NEW CRITERIA FOR INFLAMMATORY MYOPATHY IN A COLOMBIAN COHORT

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Background: Idiopathic inflammatory Myopathies are a group of diseases characterised by weakness due to muscle inflammation, with or without dermatological involvement, that classically includes pathognomonic findings like Gottron sign. There have been different criteria used to classify these diseases, being Peter and Bohan the most used in time, but recently the ARC/EULAR group proposed a new way to approach the classification.

Objectives: To compare ACR/EULAR 2017 versus Peter and Bohan criteria for Idiopathic Inflammatory Myopathy in a Colombian cohort

Methods: A cross-section retrospective research was done with data collected between 2014 and 2017 from a population diagnosed with Idiopathic Myopathy according to Peter and Bohan criteria and followed up for at least six months. The new ACR/EULAR criteria were applied to each individual using the online tool

(<http://www.imm.ki.se/biosstatistics/calculators/iim>). Both sets of criteria were compared using Cohen's kappa coefficient and concordance was evaluated.

Results: Data of 149 patients were obtained. Anti-Jo1 results were not available for 75% of the patients. Biopsy was available in 44.3% of patients. Biopsy results were compatible with inflammatory myopathy in 66.7% and non-compatible in 33.3%. According to Peter and Bohan criteria the diagnosis of idiopathic inflammatory myopathy was definite in 63.1% of the patients, and probable in 27.5%. Using ACR/EULAR 2017 criteria instead the diagnosis was definite in 63.1%, probable 10.1% and non-possible in 20.8%. According to the new criteria, 31 patients had polymyositis, 47 dermatomyositis, 4 amyopathic dermatomyositis, 35 juvenile myositis and 1 inclusion body myositis. The concordance analysis between the two sets of criteria showed agreement of 54% (kappa 0.22 $p<0.001$) in the whole group, 59% (kappa 0.21 $p<0.001$) in adults, 32% (kappa 0.18 $p=0.05$) in children, 44% (kappa 0.05 $p=0.3$) in polymyositis and 42% (kappa 0.16 $p=0.1$) in dermatomyositis.

Conclusions: Data of 149 patients were obtained. Anti-Jo1 results were not available for 75% of the patients. Biopsy was available in 44.3% of patients. Biopsy results were compatible with inflammatory myopathy in 66.7% and non-compatible in 33.3%. According to Peter and Bohan criteria the diagnosis of idiopathic inflammatory myopathy was definite in 63.1% of the patients, and probable in 27.5%. Using ACR/EULAR 2017 criteria instead the diagnosis was definite in 63.1%, probable 10.1% and non-possible in 20.8%. According to the new criteria, 31 patients had polymyositis, 47 dermatomyositis, 4 amyopathic dermatomyositis, 35 juvenile myositis and 1 inclusion body myositis. The concordance analysis between the two sets of criteria showed agreement of 54% (kappa 0.22 $p<0.001$) in the whole group, 59% (kappa 0.21 $p<0.001$) in adults, 32% (kappa 0.18 $p=0.05$) in children, 44% (kappa 0.05 $p=0.3$) in polymyositis and 42% (kappa 0.16 $p=0.1$) in dermatomyositis.

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AB1379 POTENTIAL DIAGNOSTIC SERUM IMMUNOLOGICAL MARKER PANEL IN PRIMARY AND SECONDARY OSTEOARTHRITIS IN SRI LANKAN PATIENTS

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Background: Osteoarthritis (OA) is commonly perceived as a degenerative joint disease but it is now established that inflammation contributes to OA. Though OA is categorised into primary and secondary osteoarthritis, most clinicians manage patients of both categories in a similar manner.

Objectives: The current study aimed to identify potential diagnostic markers of primary and secondary OA. Two cohorts of Sri Lankan patients, one with primary OA and another with secondary OA were assessed for a selected panel of immunologic mediators i.e. cytokines (TNF- α , IL-1 β , IL-6, IL-10) and nitric oxide derivatives (NOx).

Methods: A case control study was conducted with 40 OA patients (Primary, n=30; Secondary, n=10), and 60 age and gender matched controls (normal healthy, n=30; Systemic Lupus Erythematosus (SLE) disease control, n=30). The socioeconomic and demographic data were accrued via an interviewer administered questionnaire. Sandwich ELISAs assayed serum cytokine levels, while the 'Griess assay' measured serum NOx levels.

Results: In comparison to healthy controls, OA patients showed significantly higher serum concentrations of all five analytes tested ($p<0.05$). Patients with primary OA had significantly higher levels of TNF- α and IL-1 β and lower level of IL-6 in serum compared to disease controls (SLE) ($p<0.05$). Secondary OA patients exhibited a significant increase in serum TNF- α and IL-1 β and lower serum IL-10 levels compared to disease controls ($p<0.05$). In the two test groups, the serum levels of TNF- α and IL-6 were significantly elevated in secondary OA patients ($p<0.05$). The NOx concentrations between the two test groups was not significantly different. The Th1:Th2 cytokine ratio (TNF- α :IL-10) was significantly higher in secondary OA compared with primary OA ($p<0.05$).

The Receiver operating characteristic (ROC) curves identified TNF- α and IL-10 as potential diagnostic biomarkers of both primary OA and secondary OA compared with healthy controls. IL-1 β and IL-6 may be used specifically as diagnostic