HPR Epidemiology and public health (including prevention)

AB1412-HPR IS DIFFUSE ALVEOLAR HAEMORRHAGE IN ANCA-ASSOCIATED VASCULITIS PREDICTIVE OF POOR PROGNOSIS?

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Background: Diffuse alveolar haemorrhage (DAH) is a serious complication of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (AAV). Detailed characteristics of patients with AAV and associated DAH have been limited to case reports and a few case series, due to the rarity of the condition.¹ Prompt diagnosis is required as early treatment is crucial.

Objectives: To compare clinical manifestations, laboratory and immunological values, morbidity and mortality in patients with ANCA-associated vasculitis (AAV) with and without Diffuse Alveolar haemorrhage (DAH)

Methods: Retrospective cohort study. Data from the medical records of patients over the age of 18 were evaluated between the years 2000–2017. Ninety patients with diagnosis of AAV who met the criteria of ACR 1990 Classification or Chapel Hill Consensus Conference 2012 were included. DAH was diagnosed based on minor or major hemoptysis and/or respiratory insufficiency together with at least 1 positive result on x-ray and/or computed tomography scan. The sample was divided in two groups: with DAH (group 1) and without DAH (group 2) along the disease. We compared demographic data, Birmingham Vasculitis Activity Score (BVAS) and Five Factor Score (FFS) at the onset of the disease, hemogram, creatinine and ANCA antibodies by immunofluorescence and/or ELISA, clinical manifestations as renal, neurological, mucocutaneous, articular, cardiologic, ophthalmologic and ear, nose and throat (ENT) damage and mortality between groups.

Chi-square or Fisher's exact test was used for dichotomous variables as appropriate. P-value<0.05 was considered statistically significant. Logistic regression analysis was used to identify predictors of survival.

Results: Group 1 included 24 patients (66% male, mean age at onset of the disease 54 years). Most frequent type of vasculitis was Granulomatosis with polyangiitis (GPA) 54%. Mean BVAS 21 points and FFS 1 point. Group 2 included 66 patients: 36% male, mean age of the disease 52 years, GPA 45%, BVAS was 17 points and FFS de 0 points. Table 1 shows demographic, clinical data and mortality of each group. Logistic regression analysis showed statistically significant difference between DAH and male sex (p: 0.017 OR 6.08 CI 95% 1.37–26.92).

Abstract AB1412-HPR – Table 1

	With HAD n=24 (26.6%)	Without HAD n=66 (73.4%)	p-value	OR (CI 95%)
Male sex	16 (66.7%)	24 (36.4%)	0.011	3.50 (1.30–9.38)
BVAS	21 points	17 points	0.009	
FFS	1 point	0 point	<0.001	
Anaemia	21 (87.5%)	30 (45.5%)	<0.001	8.4 (2.28–30.91)
Mucocutaneous disease	1 (4.2%)	19 (28.8%)	0.018	0.11 (0.01–0.91)
ENT disease	7 (29.2%)	35 (53%)	0.045	0.36 (0.13–0.99)
Neurological disease	4 (16.7%)	31 (47%)	0.009	0.22 (0.07–0.73)
Renal damage	24 (100%)	31 (47%)	<0.001	1.70 (1.40–2.23)
RPGN	13 (54.2%)	12 (18.2%)	0.001	5.31 (1.92–14.71)
Dialysis	8 (33.3%)	4 (6.1%)	0.003	6.8 (1.69–27.35)
Mortality	5 (22%)	12 (21%)	0.930	1.05 (0.32–3.44)

Conclusions: DAH was associated with increased morbidity but not modified the mortality in this group of patients. The results seem to be agree on the Five Factor Score² that does not include DAH within parameters.

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AB1413-HPR ADVANTAGES OF RHEUMATOLOGY NURSING VACCINATION OF PATIENTS WITH INFLAMMATORY RHEUMATIC DISEASES OF AUTOIMMUNE ORIGIN. ANALYSIS OF THE FIRST 3 YEARS

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Background: Patients with systemic autoimmune diseases (SAD) have higher incidence of infections. In our Service, until 2014 about 50% of patients did not complete vaccination for pneumococcus or hepatitis B virus (HBV).

Objectives: To know the characteristics of vaccinated patients and advantages of vaccination by Rheumatology nurse (Nurse-RHEU).

Methods: Observational study of patients in follow-up in rheumatology, vaccinated from 2015–2017, by SAD in treatment with biological therapy and/or immunosuppressive, by Nurse-RHEU, following the recommendations from SVR and the Valencian Society of Preventive Medicine and Public Health Consensus Document for the vaccination of patients with SAD, published in 2014. Nurse-RHEU, assumed from 2015 the vaccination of all rheumatology patients with SAD. The vaccines to be administered were: pneumococcal (13 V and/or 23 V) and hepatitis B virus (HBV).

Pneumococcal vaccination should be initiated with the conjugate/13 V type and at least 8 weeks later with a dose of polysaccharide/23 V vaccine. A single 23 V booster dose is recommended 5 years after the first dose. Only if patient have received a previous dose of 23 V, it is advisable to administer type 13 V, one year later. For the HBV vaccine, it is necessary previously check the immune status of the subject. If it is not immune, 3 doses will be administered (0–1–6 months).

Since 2015, our Section has: refrigerator, electronic access to the Vaccinated Nominal Registry of the Valencian Community (it collects data of the patient, date, type, batch of vaccine administered), specific database (epidemiological data of the patients, future dose programming, access to electronic medical records) and Nurse-RHEU trained. Previously, the nurse details possible side effects, and how to act or contact.

Results: Of the 261 patients vaccinated during 2015 to 2017, 65% were women, with mean age 53.57±15.50 years (10–81 years). The diagnosis was: rheumatoid arthritis: 48%, ankylosing spondylitis: 23%, psoriatic arthritis: 13%, systemic lupus erythematosus: 7%, uveitis: 4%, and others 5%. The reason for vaccination was: initiation treatment with a biological drug (51%), or immunosuppressive (49%). A total of 621 vaccines were administered, which were: 13-valent conjugate antineumotococcal: 259 (42%), 1 st VHB dose: 94 (15%), 2nd VHB dose: 85 (14%), 3rd VHB dose: 72 (12%), pneumococcal 23-valent polysaccharide: 111 (17%). All vaccines were registered in the Vaccinated Nominal Register of the Valencian Community.

Conclusions: 1. Patients with SAD in biological treatment and/or immunosuppressant, vaccinated by Nurse-RHEU, achieve a completeness of all doses of vaccination, close to 100%. 2. In a large part of the patients, vaccination is scheduled at the beginning of the diagnosis of the disease, at the first consultation or immunosuppressive treatment, the same day of the visit to the Rheumatologist, avoiding unnecessary visits to the patient. 3. An adequate electronic registry allows immediate access to information from any point in the Valencian Community, through access to the computer program of the Health department.

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