Speaker Abstracts

WEDNESDAY, 13 JUNE 2018

WIN and HOT session

SP0001 SYSTEMIC LUPUS: ISSUES ABOUT PREGNANCY

A. Tincani. *Rheumatology and Clinical Immunology Unit, University of Brescia, Brescia, Italy*

Angela Tincani and Francesca Crisafulli

The outcome of Systemic Lupus Erythematosus (SLE) pregnancies has dramatically improved over years thanks to pregnancy planning, multidisciplinary management and close monitoring. According to EULAR recommendations,¹ pre-pregnancy counselling with the identification (and management) of possible disease related risk factors (such as active or past lupus nephritis and presence of antiphospholipid antibodies or antiphospholipid syndrome, APS), assessment of disease activity during pregnancy (including renal function parameters, anti-dsDNA and serum C3/C4) together with obstetrical monitoring are necessary to achieve a good pregnancy outcome. A recent evaluation of our SLE pregnancy cohort recruited from 1987 to 2017 showed a number of losses not significantly different to that observed in the general obstetric population; it is of interest that all the patients enrolled received pre-pregnancy counselling and were prospectively followed during gestation by a multidisciplinary team. According to this finding, a recent paper with data derived from Norwegian Registries² underlines that adverse pregnancy outcomes (APO) occur more frequently in SLE patients only in the presence of active disease.

However, the data are not univocal. A recent meta-analysis³ still underlines the higher frequency of APO such as preeclampsia (PE), spontaneous abortion, pre-term birth and small for gestational age (SGA) newborns in SLE patients. So much effort is still devoted to identify new predictors of APO and possible protective strategies.

The uterine artery Doppler applied to SLE pregnancies shows an increased mean pulsatility index while the same patients display a higher ratio of two angiogenic biomarkers (sFlt-1/PIGF) related to placental dysfunction.⁴

Furthermore, an increase of Bb and sC5b-9 levels during early phases of pregnancy was observed in SLE patients who later developed APO.⁵ A more recent work shows higher levels of Pentraxin3 (PTX3) in the general obstetric population with early-onset PE.⁶ Studying placental histology, a higher number of neutrophils and neutrophilic extracellular traps (NETs) were detected in both SLE and non-SLE pregnancies with PE as compared with controls.⁷ Taken together these observations suggest that also innate immunity could play a role in the occurrence of APO observed in this condition.

Many studies have assessed the beneficial role of hydroxychloroquine (HCQ) in SLE pregnancies. The use of HCQ is associated with a lower frequency of preterm birth and intrauterine growth restriction, less disease flares and reduction of the risk of fetal loss and SGA in patients with lupus nephritis. On the other hand, the use of prednisolone was associated with lower birth weight and higher rate of preterm birth.² In our cohort, the exposure to corticosteroids in doses greater than 35 mg/week in the 1st trimester was associated with preterm birth (<37 th weeks), while in the 3rd trimester with severe preterm birth (<34 th weeks). A recent study had assessed the improvement of pregnancy outcome in women with refractory obstetric APS treated with pravastatin⁸; given the strong association between SLE and APS, this could be an interesting topic to develop in the future.

The interest in long-term outcome of children born to mother with SLE raises from few observational studies suggesting an increased risk of neurodevelopmental disorders, congenital heart defects and autoimmune diseases. However, the risk of these adverse outcomes is small, and the large majority of children are in good health. Recently, the neurodevelopmental status of 40 children (median age 7.4 years) born to women carrying antiphospholipid antibodies (with or without SLE) was investigated by child neurologists and psychiatrists. All the children resulted normally intelligent but a slight increase in the frequency of epilepsy, sleep disorders and learning disability was observed.⁹ In this respect, a recent study performed in animals pointed out the role of HCQ as protector of fetal brain development, offering a possible future preventive strategy.¹⁰

In conclusion, most of the young women affected by SLE can now carry out one or more pregnancies thanks to the improvement in prevention, early recognition and treatment of pregnancies complications. Nevertheless, further studies are necessary to reduce the risk of pregnancy morbidity still reported in some patients.

REFERENCES:

- [1] Andreoli L, et al. *Ann Rheum Dis* 2017;76(3):476–485.
- [2] Skorpén CG, et al. *Ann Rheum Dis* 2018;77(2):264–269.
- [3] Bundhun PK, et al. *J Autoimmun* 2017;79:17–27.

- [4] Rodríguez-Almaraz ME, et al. *Pregnancy Hypertens* 2018;11:99–104.
- [5] Kim MY, et al. *Ann Rheum Dis* 2018;77(4):549–555.
- [6] Akhter T, et al. *Int J Cardiol* 2017;15:241–417–422.
- [7] Marder W, et al. *Lupus Sci Med* 2016 27;3(1):e000134.
- [8] Lefkou E, et al. *J Clin Invest* 2016 1:126(8):2933–40.
- [9] Nalli C, et al. *Lupus* 2017;26(5):552–558.
- [10] Bertolaccini ML, et al. *J Autoimmun* 2016;75:30–38.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7868

WEDNESDAY, 13 JUNE 2018

Little arthritis in PsA and axSpA with newly onset arthritis – does it matter?

SP0002 PSA BEYOND THE TYPICAL POLY-ARTICULAR PHENOTYPE: HOW TO DEAL WITH THIS IN CLINICAL PRACTICE?

E. Nikiphorou. *Academic Rheumatology, Kings College London, London, UK*

This lecture will focus on the case of a psoriatic arthritis (PsA) patient presenting primarily with enthesal disease rather than the usual poly-articular phenotype. The case discusses issues around misinterpretation of signs and symptoms leading to inappropriate diagnoses and failure to early disease recognition and therefore treatment. Consequences of delayed treatment and less typical presentations of PsA will be discussed in greater detail during the session, highlighting important diagnostic and management aspects of disease, relevant to routine clinical practice.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7654

SP0003 AXSPA PATIENT WITH PERIPHERAL MANIFESTATIONS

A. Sepriano. *Rheumatology, Leiden University Medical Centre, Leiden, Netherlands*

A case of a 32 year old Caucasian, female patient referred to an outpatient rheumatology clinic with a 3 month history of low back pain and a 2 week duration severe left heel pain is presented. Disease presentation, including findings on physical examination, laboratory tests and imaging are discussed, as well as their potential impact on treatment decisions.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7653

SP0004 EXTRA SPINAL MANIFESTATIONS IN AXIAL SPONDYLOARTHRITIS

M. Dougados. *Hopital Cochin, Paris, France*

The extra-spinal manifestations in axial spondyloarthritis can be categorised in 2 main sub-groups: the extra-spinal rheumatological manifestations on one hand and the extra rheumatological manifestations in the other hand.

The extra spinal manifestations comprise synovitis, dactylitis and enthesitis and extra rheumatological manifestations comprise mainly skin psoriasis, uveitis and inflammatory bowel disease.

In terms of diagnostic approach in case of a patient presenting with axial symptoms, the probability to detect any extra-spinal manifestations in the past-history of the patients and/or concomitantly to the axial symptoms is very high (>75% at the baseline visit of the DESIR cohort including patients with recent onset axial symptoms suggestive of spondyloarthritis). These manifestations (based on data from different databases: for example the DESIR cohort and the ASAS-COMO-SPA cross-sectional study) will be described

The long term follow-up of patients presenting with axial spondyloarthritis emphasises the possibility to observe these extra-spinal manifestations overtime (incident cases).

These data are strong arguments to

1. Justify the inclusion of these extra-spinal manifestations in the set of classification criteria of axial spondyloarthritis
2. Justify specific investigations (mainly interview and physical exam) of the patients at the time of the diagnosis
3. Justify a systematic monitoring of these different extra-spinal manifestations during the entire course of the disease

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7651

WEDNESDAY, 13 JUNE 2018

Cancer and inflammation

SP0005 INFLAMMATION AND CANCER: FRIEND OR FOE

C.S. Roxburgh. Academic Unit of Surgery, University of Glasgow, Glasgow, UK

Cancer associated inflammation and the host immune response are key determinants of progression and outcome in solid malignancies. There is now persuasive evidence that inflammation is key to tumourigenesis via dna damage, stimulation of angiogenesis and proliferation, and inhibition of apoptosis. there have long been suspicions that dysregulated immune and inflammatory responses promote the progression and dissemination of established cancers and there is a heightened risk of cancer development in individuals with chronic inflammatory diseases. the tumour microenvironment is now viewed as a battleground for pro-tumour and anti-tumour responses. We now see an increase array of novel therapeutic targets targeting innate and adaptive components of the immune response to cancer. ONCO-Immunology with immunotherapy are an established part of clinical practice differing from conventional anti-cancer treatments in that the strategies do not principally target cancer cells. This talk will focus on the evidence that inflammation influences malignant progression in gi malignancy discussing novel therapeutic strategies.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7859

WEDNESDAY, 13 JUNE 2018

Psychological distress and pain; not all in the mind.

SP0006 DISTRESS AND PAIN: INTEGRATED BRAIN PATHWAYS

B. Sundermann. Institute of Clinical Radiology, University Hospital Muenster, Muenster, Germany

The focus of functional and multimodal neuroimaging studies has been switching from individual brain areas to larger interacting networks in the human brain. Regions within a network as well as different networks interact with each other and are usually involved in multiple brain functions such as perception, attention or cognitive control. In this presentation we will review the current knowledge on brain networks which are involved in the processing of painful stimuli or altered in patients suffering from chronic pain and how these share network correlates implicated in distress.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7764

SP0007 DEALING WITH PSYCHOLOGICAL DISTRESS TO OPTIMISE OUTCOMES FOR ARTHRITIS PAIN

R.J. Smeets. Rehabilitation Medicine, Maastricht University, Maastricht, Netherlands

As clinicians we are often confronted with patients who suffer from arthritis pain. As most of us working in the field of arthritis, we are specifically trained to assess and treat medical causes in order to relieve pain. However, in daily practice we experience that many patients will develop chronic pain with huge problems in staying active and experiencing moderate to high levels of disability and lower level of quality of life.

In my opinion all clinicians should be able to identify psychosocial factors that contribute to the persistence of arthritis pain associated disability and loss of quality of

life. Besides these patient relevant psychosocial factors, I will specifically focus on the important role clinician's beliefs/attitudes regarding pain in better treating and coaching patients with chronic arthritis pain.

Participants will learn how to look for these potentially contributing factors, how to diagnose the level of functioning of these patients and how to inform patients about their pain and role of important contributing psychosocial factors. I will discuss the way how you might better prescribe pain medication and other pain relieving treatments and finally how you can help them to stay active despite being in pain, reduce the risk of iatrogenic damage, and what type of treatments exist to address contributing psychosocial factors.

Finally, I will specifically elaborate on the Fear Avoidance Model as one of the currently most often used theoretical models to assess patients and on which basis a very successful treatment called graded exposure *in vivo* has been developed.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7796

WEDNESDAY, 13 JUNE 2018

Inflammation in the shadow of fibromyalgia

SP0008 A RA WITH PERSISTANT HIGH DISEASE ACTIVITY UNDER BIOLOGICAL TREATMENT: HOW DOES CHANGING DIAGNOSIS CHANGE MANAGEMENT AND OUTCOME?

A.P. Trouvin. Pain Evaluation and Treatment Department, Hopital Cochin, Paris, France

We shall discuss the clinical case of a 45 years old woman. She has been diagnosed with rheumatoid arthritis, rheumatoid factor and ACPA are positive, acute phase reactants were elevated and no erosion was detected on the initial X-Rays. After a first line treatment with a conventional DMARD during 18 months, she experienced new flares with multiple synovitis and with elevated acute phase reactants. A TNF-inhibitor treatment was initiated. After 3 months, low disease activity was not reached hence biologic treatment was switched to abatacept. After 3 months, the patient still complained of pain in her hands and feet but acute phase reactants normalised, DAS-28 score is 5,20 (TJC: 18 , SJC: 0, ESR 14 mm/h, VAS general health patient: 70/100). Question rose to change biological therapy once again. The case presentation will discuss how a possible fibromyalgia can, in this case, be confounding in the patient's clinical evaluation and therefore change the management of the patient.

We shall discuss the clinical case of a 45 years old woman. She has been diagnosed with rheumatoid arthritis, rheumatoid factor and ACPA are positive, acute phase reactants were elevated and no erosion was detected on the initial X-Rays. After a first line treatment with a conventional DMARD during 18 months, she experienced new flares with multiple synovitis and with elevated acute phase reactants. A TNF-inhibitor treatment was initiated. After 3 months, low disease activity was not reached hence biologic treatment was switched to abatacept. After 3 months, the patient still complained of pain in her hands and feet but acute phase reactants normalised, DAS-28 score is 5,20 (TJC: 18 , SJC: 0, ESR 14 mm/h, VAS general health patient: 70/100). Question rose to change biological therapy once again. The case presentation will discuss how a possible fibromyalgia can, in this case, be confounding in the patient's clinical evaluation and therefore change the management of the patient.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7722

SP0009 FIBROMYALGIA ONSET OF SYSTEMIC LUPUS ERYTHEMATOSUS?

N. Hassan. Rheumatology, University Hospital of Wales, Cardiff, UK

Systemic lupus erythematosus (SLE) and fibromyalgia often pose a diagnostic challenge to clinicians. The two conditions can coexist and the presence of one can complicate the diagnosis and management of the other. There is an increased prevalence of fibromyalgia amongst SLE patients compared to the general population but the exact nature of this association is not yet fully understood. We describe a patient diagnosed with fibromyalgia who later went on to develop SLE.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7747