Conclusions: In SSc-patients, TA were predominantly located on the face, hands and the upper part of the trunk. They may reflect the vasculopathy of SSc and could represent a clinical biomarker for vascular disease, particularly for PH, one of the most severe vascular complications of the disease.

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[6] Zhang S, Xu D, Li M, et al. Telangiectasia as a potential clinical marker of one of the most severe vascular complications of the disease. In SSc-patients, TA were predominantly located on the face, hands and the upper part of the trunk. They may reflect the vasculopathy of SSc and could represent a clinical biomarker for vascular disease, particularly for PH, one of the most severe vascular complications of the disease.

ASSOCIATION OF INFLAMMATORY MARKERS C-REACTIVE PROTEIN AND ERYTHROCYTE SEDIMENTATION RATE WITH PULMONARY FUNCTION TESTS AND EUROPEAN SCLERODERMA STUDY GROUP ACTIVITY INDEX (ESCSG-AI) IN SYSTEMIC SCLEROSIS – ASSOCIATED INTERSTITIAL LUNG DISEASE IN FOLLOW UP STUDY

O.B. Ovsyannikova, O. Koneva, L. Ananieva. Department Of Vascular Pathology, Nasonova Research Institute of Rheumatology, Moscow, Russian Federation, Moscow, Russian Federation

Background: Inflammatory markers are very important to assess severity and activity of SSC-ILD, but it’s role needs further investigation.

Objectives: To assess inflammatory markers of SSC such as hsCRP and ESR and compare with lung function test and ESCsG-SG-AI in the long-term follow up study.

Methods: It was a longitudinal study involving 77 pts with SSC-ILD (mean age was 46.2±13.4; 69% have limited subset of the disease; 93% were female). The mean duration of follow up was 58.9±11.4 months. Pts were investigated with HRTC twice (at first visit and at the end of the study) and according the CT-changes were divided into 3 groups: the 1st group (16 pts) with improvement; 2nd group (39 pts) without any changes and 3rd group (22 pts) with worsening of fibrosis. Other data collected including biological results (high-sensitivity C-reactive protein (hsCRP) and erythrocyte sedimentation rate (ESR)). PFT (forced vital capacity (FVC),% of predicted) and diffusion capacity of the lung for carbon monoxide (DLCO, % of predicted), composite score (ESCsG-AI).

Results: There were no significant differences between groups related to sex, frequency of diffuse form and duration endpoints. Mean levels of hsCRP and ESR didn’t change significantly during the follow up. In all pts the mean levels of hsCRP and ESR correlated directly with each other at first visit and at the end of the study (R=0.45 and R=0.4 (p<0.01) accordingly). We compared the mean levels of hsCRP and ESR with mean dates of FVC, DLCO and ESCsG-SG-AI score in first visit and the end of follow up. Mean levels of hsCRP inversely correlated with mean dates of FVC at the first visit and at the end of the study (R=0.39 and R=0.42 (p<0.05) accordingly); in groups 2 and 3 (R=0.34 and R=0.47 (p<0.05) accordingly) at the end of the study; with mean dates of FVC in all pts and group 2 (R=0.42 and R=0.47 (p<0.05) accordingly) only at the end of the study; correlated directly with ESCsG-SG-AI score in all pts and groups 2,3 (R=0.58 (p<0.0001), R=0.46 (p<0.01) and R=0.77 (p<0.001) accordingly) at the end of the study; while mean levels of ESR inversely correlated with mean dates of DLCO only in all pts and groups 1,2 (R=0.43, R=0.66 and R=0.39 (p<0.05) accordingly) at first visit; correlated directly with ESCsG-SG-AI score in all pts (R=0.309 (p<0.01) at the end of the study. Mean levels of hsCRP inversely correlated with DLCO, FVC and directly correlated with ESCsG-SG-AI and these correlations were more evident than mean levels of ESR.

Conclusions: In our group of pts, the hsCRP has proven to be an accurate reflection of disease severity especially in pts with progression of ILD.