positive for ANCA (SLE, sclerosis, RA, RA/RV). This study shows that the PR3- and MPO-ANCA ELISAs are highly specific (93.2%/94.2%) and sensitive (85.9%/86% in the detection of ANCA to identify AAV or conditions known to be associated ANCA.

Conclusions: Our comparison of PR3- and MPO-ANCA ELISAs showed (i) a high diagnostic performance of these PR3- and MPO-ANCA ELISAs to discriminate AAV from disease controls. (ii) very good correlation between the other methods tested. In conclusion, these novel assays can be used as screening method for detection of ANCA in patients with related diseases.

Disclosure of Interest: None declared


FR0651 QUANTITATIVE CHEST CT PREDICTS 8-YEARS-MORTALITY AND COMORBIDITY IN SYSTEMIC SCLEROSIS

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Background: Intestinal Lung Disease (ILD) is the main cause of death in Systemic Sclerosis (SSc). Severe lung involvement increase the hospitalization rate and sometimes oxygen therapy is required. An prompt treatment in ILD-SSc patients is essential, but nowadays there is not a feasible method to identify patients with poor prognosis.

Although chest Computed Tomography (CT) is the gold standard to detect ILD, there is no standard assessment of its severity. Quantitative CT (QCT) is an innovative and operator independent method to assess ILD-SSc extent and severity. An increasing number of evidences confirm that QCT is extremely useful for detecting SSc-ILD with the worst prognosis. However is not well established if QCT can predict death or comorbidity associated to ILD.

Objectives: The main aim of this study is to verify if QCT predict 8-years mortality or clinical worsening (i.e. hospitalization for respiratory complications or chronic oxygen therapy) in SSc.

Methods: Consecutive SSc patients (according to ACR/EULAR classification criteria) from ten different centers underwent a chest CT. Their clinical history was carefully recorded in the following 96 months. A rheumatologist post-analyzed every CT with an open source DICOM viewer in order to obtain QCT indexes. Patients were clustered in two subgroups: according to QCT indexes’ cutoffs previously found (see Ariani et al., 2017). The survival time of each patient was considered the time interval between the CT date and death, hospitalization related to lung worsening, beginning of chronic oxygen therapy or last medical examination

Results: We enrolled 342 patients; during the 8-years follow-up 15.5% (53/342) died and 4.4% (15/342) had a clinical worsening. The Kaplan-Meier survival analysis demonstrates a worse survival in patients with QCT indexes above or below the previously observed cutoffs. (p<0.01). In particular the QCT index cutoff which the best performance was total lung kurtosis (Kurt) equal to 4.89 (p<0.0001).

REFERENCES: The QCT indexes’ cutoffs previously found (see Ariani, et al., 2017) identify the SSc-ILD subjects with an high risk of 8-years mortality and comorbidity. These findings suggest that QCT could become a pivotal assessment in SSC management because its role in identifying patients with poor prognosis and who deserve an early aggressive treatment.

Disclosure of Interest: None declared


FR0652 THE DEVELOPMENT AND VALIDATION OF FAMILIAL MEDITERRANEAN FEVER QUALITY OF LIFE SCALE (FMF-QOL)

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Background: Quality of life (QoL) was negatively affected in FMF patients. A QoL scale specific to FMF is not existing in the literature.

Objectives: To develop valid and reliable quality of life scale in familial Mediterranean fever (FMF).

Methods: The psychometric method was used to develop the FMF-Qol. In the first step, the question pool was formed by using existing QoL scales in the literature. Outpatients with FMF according to Livneh criteria were recruited. After patients’ interviews, some identical and irrelevant questions eliminated and new ones were added by an expert committee. Cognitive debriefing interviews concerning Qol were done with another 20 FMF patients. Minor changes (few words) after these interviews were made. In the second step, the preFMF-Qol with 101 questions was formed and it was filled out by FMF patients. Confirmatory factor analysis (CFA) by varimax rotation, assessment of data’ skewness and kurtosis, evaluation of invalid questions and participants were performed. After this, the internal consistency with Cronbach alpha was calculated. The face, content and construct validities were assessed. Convergent validity which was the relation of the FMF-Qol with functional parameters (欧洲Health Impact Scale) was assessed. The discriminative validity which was the relation of the FMF-Qol with nonfunctional parameters such as demographic and clinical characteristics were analyzed.

Disclosure of Interest: None declared


FR0653 VALIDITY OF POLYMYALGIA RHEUMATICA DIAGNOSIS, AND CLASSIFICATION CRITERIA, IN PRIMARY HEALTH CARE

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Background: Polymyalgia rheumatica (PMR) is an inflammatory disorder that mainly affects elderly women, and usually is diagnosed in primary health care (PHC). A number of classification criteria have been proposed, most recently the American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) criteria from 2012 (1). The ACR/EULAR criteria were developed in a cohort of patients recruited from rheumatology clinics.

Objectives: To examine the validity of PMR diagnoses in primary care, and to validate the use of classification criteria for PMR in a retrospective survey of a PHC cohort.

Methods: Patients were recruited from two PHC centers. All patients with a registered diagnosis of PMR between 2000 and 2013 in the patient administrative system were identified. The electronic case records, including hospital records,
for all patients were reviewed through June 2015. Patients with a diagnosis of PMR prior to 2000, or at another care facility, and those with an incorrectly regis-
tered PMR diagnosis code, were excluded. In a structured review of the case
records, information required for classification according to the ACR/EULAR crite-
rria, the Bird criteria, the Healey criteria, the Chuang&Hunder criteria and the Jone-
s&Hazelman criteria was extracted. For the ACR/EULAR criteria, a modified
version, in which patients who had never been tested for rheumatoid factor (RF)
and anti-citrullinated peptide antibodies (ACPA) only required 2 points to be clas-
sified as having PMR, was used. Furthermore, as duration of morning stiffness
(NU) was usually not recorded, criteria components for NU were considered to be
fulfilled whenever MS was mentioned in the records. The reference method was
an independent review, with assessment of the long term disease course and dif
ferential diagnoses, by an experienced rheumatologist with access to all elec-
tronic records.
Results: A total of 305 patients with a registered diagnosis of PMR were
reviewed. Of these, 117 were excluded. Among 188 with an incident PMR diagno-
sis at the study sites during the study period, 49 (26 %) fulfilled the modified ACR/
EULAR criteria, whereas 145 (77 %) fulfilled the Bird criteria and 93 (49 %) fulfilled
the Healey criteria. Patients could not be classified according to the Chuang&Hun-
der or the Jones&Hazelman criteria due to missing data in most patients for sev-
eral components. RF and ACPA were tested in only 42 cases (4 positive) and 29
cases (none positive), respectively. The PMR diagnosis was verified using the
reference method in 113 cases (60 % of total; 68 % female, mean age at diagnosis
75 years). Among those fulfilling the modified ACR/EULAR criteria, the diagnosis
was verified in 84 % of the patients. The corresponding proportion for the Bird
criteria was 68 %, and for the Healey criteria 74 %.

Conclusions: In this study of patients with PMR diagnosed in PHC, the diagno-
sis could be verified in 60 % of the patients. This underlines the heterogeneity
of PMR patients and related diagnostic procedures in PHC. A modified version
of the ACR/EULAR criteria can be used to identify patients with a valid PMR diagno-
sis in retrospective surveys, but does not capture all PMR patients. The modified
ACR/EULAR criteria appear to be more stringent than some of the older criteria
sets.

REFERENCE:

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L, de Wit M, Dijkmans BA, Dougados M, Engelbrecht M, Gogus F, Heiberg T, Kir-
wans JR, Mola EM, Cerrnic MM, Otsa K, Sokka T
Disclosure of Interest: None declared


FR0654
IS THE PATIENT-ACCEPTABLE STATUS SIMILAR
ACROSS 3 DIMENSIONS OF HEALTH IN PATIENTS WITH
RHEUMATOID ARTHRITIS (RA)? POST-HOC ANALYSES
FROM THE VALIDATION IN 549 PATIENTS OF THE
RHEUMATOID ARTHRITIS IMPACT OF DISEASE (RAID)
SCORE

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Background: Patient Acceptable Symptom State (PASS) is the highest accep-
table level of symptoms which patients consider satisfactory. In the Rheumatoid
Arthritis Impact Disease (RAID) questionnaire, seven domains of health of impor-
tance for RA patients are collected.1 It is possible that levels judged acceptable
by patients vary according to the domain of health.

Objectives: To explore the relationship between seven RA domains of health
(collected in the RAID) and PASS, and to define their PASS cut-off values.

Methods: This was a post-hoc analysis of the cross-sectional study for RAID vali-
dation. Each of 7 domains (table 1) was evaluated through a Numeric Rating
Scale from 0 (best) to 10 (worst). PASS was calculated using the anchored
method based on patients‘ perspective. Disease activity was assessed based on the
DAS28–3 values (joint counts and ESR). Comparison of patients in PASS or
not was assessed through Mann-Whitney or Chi-square test, as adequate. Varia-
bles with p<0.05 were included in multivariate logistic regression (Forward Condi-
tional) analysis. The methods of PASS for each domain were calculated using the
receiver-operating characteristic (ROC) curve and the optimal cut-off was deter-
mined through Youden Index. 75th percentile analyses were also performed
(not shown).

Results: 549 patients [78% female, mean age 56.7 years, mean disease dura-
tion 12.3 years, mean (SD) DAS 28–3 2.7(1.2)] were analysed. The majority of patients
(80.7%) considered themselves to be in PASS. Disease activity (DAS
28–3 mean 2.3 vs 3.4, p<0.01) and all seven domains of health were significantly
lower in patients in PASS versus not in PASS (p<0.001). In multivariate analyses, lower
disease activity (OR 0.72; 95%CI 0.56–0.92), lower pain (OR 0.75; 95%
0.65–0.86) and better physical well-being (OR 0.74 95%; IC 0.65–0.85) were associated
with being in PASS.

The cut-off for PASS was 5.2 for the total RAID score but varied across the seven
domains (table 1), with Pain (5) and Fatigue (5) having the highest acceptability
cut-offs. Sleep Disturbance and Coping were the domains with lowest thresholds
compatible with PASS (3).

Table 1: Thresholds for Acceptable Status for each RAID domain, AUC: Area Under the
Curve, and sensitivity and specificity versus PASS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Cut-off</th>
<th>AUC</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>≤5</td>
<td>0.84</td>
<td>80.5</td>
<td>72.9</td>
</tr>
<tr>
<td>Function</td>
<td>≤4</td>
<td>0.82</td>
<td>69.7</td>
<td>80.8</td>
</tr>
<tr>
<td>Fatigue</td>
<td>≤5</td>
<td>0.75</td>
<td>74.9</td>
<td>62.2</td>
</tr>
<tr>
<td>Sleep</td>
<td>≤3</td>
<td>0.70</td>
<td>64.2</td>
<td>67.4</td>
</tr>
<tr>
<td>Emotional Well-</td>
<td>≤4</td>
<td>0.76</td>
<td>75.0</td>
<td>64.5</td>
</tr>
<tr>
<td>Being</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Well-</td>
<td>≤4</td>
<td>0.81</td>
<td>69.3</td>
<td>77.1</td>
</tr>
<tr>
<td>Coping</td>
<td>≤3</td>
<td>0.79</td>
<td>65.5</td>
<td>77.1</td>
</tr>
</tbody>
</table>

Conclusions: Pain and physical well-being appeared as major drivers of PASS.
The cut-offs defining PASS were not the same for all RAID domains, indicating
that being in PASS doesn’t mean the same acceptable severity for all domains
of health. This observation suggests that individualised management, for each
domain, should be considered.


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Disclosure of Interest: None declared