SAT0192

MYOSITIS IN PATIENTS WITH PRIMARY SJÖGREN'S SYNDROME: DATA FROM A FRENCH NATIONWIDE SURVEY

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Background: Myositis is recognized as a manifestation of primary Sjögren's syndrome (pSS). Grading muscle involvement using the EULAR Sjögren Syndrome Disease Activity index (ESSDAI) does not require biopsy-proven active myositis or extensive immunological investigations. However, several studies have reported that a high proportion of pSS-associated myositis is either inclusion body myositis (IBM) or an overlap with idiopathic inflammatory myopathies.

Objectives: The objective of our study was to investigate the nature of inflammatory muscle involvement in a large sample of patients with pSS and concurrent myositis.

Methods: We conducted a French nation-wide survey among reference centers known for their experience in the field of systemic auto-immune diseases. Patients with physician-based diagnosis of pSS and inflammatory muscle involvement were included. They were categorized and subsequently described and compared according to the identification of an associated condition likely to explain inflammatory muscle involvement.

Results: 60 cases of myositis in patients with pSS were identified. Patients were mostly female (52/60) and pSS classification criteria were met in 43/60. Muscle biopsy was performed in 50/60 patients and showed inflammatory lesions in 80% of cases. An associated condition likely to explain myositis was identified in 31 patients: typical dermatomyositis rash (n=8), MCTD-specific antibodies (n=11), myositis specific antibodies (n=10), and systemic lupus erythematosus, scleroderma or ANCA associated vasculitis specific antibodies in favor of an overlap syndrome (n=7). Among the 29 patients without associated condition likely to explain myositis, 17 had a biopsy proven inflammatory muscle disease, showing histopathologic features consistent with IBM in 5 cases. 4 of the 5 patients with IBM histological features received corticosteroids and/or other immunosuppressive agents to treat muscle disease. Worsening of muscular involvement despite treatment was reported in these 4 patients. Comparative analysis showed a lower ESSDAI ($p = 0.001$) among patients without identified associated condition likely to explain myositis.

Conclusion: In most cases of concurrent pSS and myositis, inflammatory muscle involvement is explained by a context of overlap syndrome or has a histological pattern consistent with IBM. Extensive immunological investigations and muscle biopsy appear to be necessary in pSS patients with suspected inflammatory muscle involvement, in order to avoid misclassification and/or overtreatment.

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SAT0193

THE USE OF A SYMPTOM CHECKLIST TO RECOGNISE PATIENTS WITH COMORBID FIBROMYALGIA ON A BACKGROUND OF SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Fibromyalgia (FM) and systemic lupus erythematosus (SLE) are both characterised by non-specific symptoms such as pain and fatigue. To make diagnosis even more challenging, fibromyalgia is overrepresented in the SLE population.

Objectives: To identify which symptoms can discriminate between patients with comorbid FM and patients without comorbid FM in the SLE population, using a routinely distributed questionnaire.

Methods: Patients with SLE (n=88) completed a Multi-Dimensional Health Assessment Questionnaire (MDHAQ) [1] and the 2011 FM Criteria questionnaire [2]. FM status was determined using the 2016 modification of the 2010/2011 FM criteria [3]. The MDHAQ contains a 60-item symptom checklist section, giving a score of 0-60. Patients with complete data were analysed for specific symptoms that were discriminating for FM using student's t test with Bonferroni correction.

Results: SLE patients with FM reported a higher prevalence of positive responses for every symptom except for 'dark or bloody stools' and 'burning in sexual organs'. Nineteen symptoms demonstrated a significant difference between those with and without FM. The most discriminating symptoms were muscle pain, swelling (of hands, ankles and in other joints), back pain, neck pain, problems with thinking and dry mouth (all $p < 0.0001$). Grouping the above 8 symptoms, a cut-off of ≥ 4 gave a sensitivity of 91% and specificity of 88%, correctly classifying 89% of patients when compared to FM criteria. Overall, patients with FM reported a mean total of 23.6 items on the symptom checklist, compared to 8.09 for patients without FM.

Conclusion: The symptom checklist section of the MDHAQ can provide clues that help discriminate between SLE patients with and without FM. Clinicians can find valuable information in the specific symptoms experienced by the patient, as well as the overall number of symptoms. Grouping the discriminatory symptoms together in the questionnaire may assist clinicians to consider the diagnosis of FM more easily in patients with SLE.

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SAT0194

EVALUATION OF PSYCHOMETRIC PROPERTIES OF THE PATIENT-REPORTED OUTCOMES MEASUREMENT INFORMATION SYSTEM (PROMIS) PHYSICAL FUNCTION 10-ITEM SHORT FORM IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: While the PROMIS (Patient-Reported Outcomes Measurement Information System) physical function short form 10a (PF10a) is both practical and acceptable for implementation in routine clinical practice, its psychometric properties have not been evaluated in Systemic Lupus Erythematosus (SLE).

Objectives: The objectives of our study were to examine the validity and responsiveness of PF10a in SLE among a racially/ethnically diverse clinic population and develop estimates of the minimally important difference (MID).