duration of follow-up was 15 months (range 3-59). At the end of the follow-up period, 10 of the 13 patients (77%) were still in treatment. In 2 patients (15%) the therapy failed, requiring lung transplantation in 1 case (after 7 months of therapy), while an autologous hematopoietic stem cell transplant was conducted in the other patient (after 13 months of anti-fibrotic). In one patient (8%) the treatment was discontinued due to adverse effects.

When quantifying the degree of response in patients who continued treatment, only 9 of the 10 patients were included in the analysis, since 1 had only 3 months of therapy. In these 9 patients there was an improvement of % pFVC (mean: +5.13; SD: 8.38) and % pDLCO (+4.42; SD: 5.06). The evolution of the efficacy variables analyzed is shown in the table.

The response in the Pulmonary function testing (PFT) in these 9 patients categorized according to the definitions of the American Thoracic Society was as follows: A) % pFVC: stabilization in 5 cases and improvement in 4; B) % pDLCO: stabilization in 7 cases and improvement in 3.

The frequency of adverse effects was 31% (4/13), but only the treatment was withdrawn in 1 patient (8%). Three patients presented digestive discomfort that forced to reduce the dose of the antifibrotic. One patient developed a toxic hepatitis due to nintedanib after 4 months of treatment that forced the withdrawal of the drug, replacing it 1 month ago with pifedronide. None of the patients died during the follow-up period.

Conclusion: Our data provides evidence of the safety and tolerability of both pifedronide and nintedanib in patients with DIDL-SAD refractory to GC and immunosuppressant therapy.

Disclosure of Interests: Marta Aguilar-Zamora: None declared, J. Narváez Consultant for: Bristol-Myers Squibb, Juanjo J Alegre-Sancho: None declared, Vanesa Vicens: None declared, Maria Molina: None declared, Joan Miquel Nolla: None declared

DOI: 10.1136/annrheumdis-2019-eular.7835

SAT0257

THE SIGNIFICANCE ON THE TRANSITION THROUGH DIFFERENT PATTERNS OF NAILFOLD MICROVASCULAR DAMAGE ON THE COURSE OF SYSTEMIC SCLEROSIS

Slavica Pavlov-Dolijanovic, Nemanja Damjanov, Nada Vujasinovic Stupar. *Institute of Rheumatology, School of Medicine University of Belgrade, Belgrade, Serbia*

Objective: To investigate the timing of transition through different patterns of nailfold microvascular damage in systemic sclerosis (SSc) patients and to determine the significance of this transition.

Methods: In the period January 2012 to December 2017, 400 SSc patients were followed up by nailfold videocapillaroscopy (NVC) the same operator (SPD) every 6 months. Demographic, clinical and laboratory data were recorded. The capillaroscopic findings were classified as normal, nonspecific or scleroderma pattern ("early", "active", or "late"). The evolution on the NVC pattern over time was monitored and recorded.

Results: The transition of microvascular damage through different NVC patterns of microangiopathy was seen in 53/400 (13.25%) SSc patients. At the baseline 11/53 (21%) patients had the non-specific changes, the early pattern had 25/53 (47%) patients, and the active pattern had 17/53 (32%) SSc patients. The mean $\pm$ SD time of progression from one to another NVC patterns was 27.68 ± 35.11 months. Improvement of the NVC patterns was found in 15/53 (28%) patients and deterioration in the remaining 38 (72%) patients. The mean time of progression from non-specific to early pattern (in 10 patients) and non-specific to active pattern (in 1 patient) was 14.5 ± 9.73 vs. 12 months, respectively. Time of changed from early to nonspecific (in 7 patients), early to active (in 17 patients) and early to late pattern (in 1 patient) was 30.85 ± 22.56 vs 22.29 ± 16.61 vs 24 months, respectively. Time of changed from active to early (in 8 patients) and active to late pattern (in 9 patients), was 26.25 ± 11.1 vs 18.00 ± 13.97 months, respectively. Progression of non-specific to early or active NVC pattern was related with limited form of SSc (91%), diffuse hand swelling (54%), arthralgia/arthritis (45%) and involvement of lungs (48%). Also, progression of early to active NVC pattern was related with limited form of SSc (64%), sclerodactyly (48%) and involvement of lungs (48%). In contrast, progression of active to late NVC pattern was related with diffuse form of SSc (53%), digital ulcerations (35%) and more frequent involvement of lungs (65%). These differences in the frequency of involvement of certain organs were not statistically significant.

Conclusion: These results demonstrate dynamic transition of microvascular damage through different NVC patterns of microangiopathy in about 13% of SSc patients. Patients with rapid progression from the early to active, as well as active to the late NVC patterns (<2 years) should be

monitored closely, because they are at risk of further significant damage to the internal organs.

Disclosure of Interests: Slavica Pavlov-Dolijanovic: None declared, Nemanja Damjanov Grant/research support from: AbbVie, Pfizer and Roche, Consultant for: AbbVie, Gedeon Richter, Merck, Novartis, Pfizer and Roche., Speakers bureau: AbbVie, Gedeon Richter, Merck, Novartis, Pfizer and Roche., Nada Vujasinovic Stupar: None declared

DOI: 10.1136/annrheumdis-2019-eular.2232

SAT0258

SEXUAL HEALTH IMPAIRMENT IN WOMEN WITH SYSTEMIC SCLEROSIS

Barbora Heřmánková¹, Maja Špiritović¹, Hana Smucrova², Sabina Oreska^{2,3}, Hana Štorkánová^{2,3}, Kristyna Bubova^{2,3}, Karel Pavelka^{2,3}, Jiří Vencovsky^{2,3}, Ladislav Šenolt^{2,3}, Radim Bečvář^{2,3}, Michal Tomčík^{2,3}. ¹Faculty of Physical Education and Sport, Charles University, Prague, Czech Republic; ²Institute of Rheumatology, Prague, Czech Republic; ³1st Faculty of Medicine, Charles University, Department of Rheumatology, Prague, Czech Republic

Background: Systemic sclerosis (SSc) is a chronic autoimmune disease that may affect all aspects of life including sexual function.

Objectives: To assess sexual function, pelvic floor function and sexual quality of life women with SSc compared to age-/sex-matched healthy controls (HC). To subanalyze sexual function in sexually active individuals.

Methods: In total 47 women with SSc (mean age: 50.5, disease duration: 5.6 years, lcSSc/dcSSc: 27/20, mRSS: 12.7, ESSG activity index: 2.5), who fulfilled the ACR/EULAR 2013 criteria, and 47 healthy women (mean age: 50.5) filled in 11 well-established and validated questionnaires assessing sexual function, pelvic floor function, quality of life, fatigue, physical activity and depression. Data are presented as mean $\pm$ SEM.

Results: Compared to HC, patients with SSc had significantly higher prevalence and greater severity of sexual impairment (FSFI, BISF-W), pelvic floor dysfunction (PISQ-12, PFIQ7), and worse sexual quality of life (SQoL-F) (table 1). There were no significant differences in sexual function between limited and diffuse SSc. Even sexually active SSc patients reported significantly greater sexual health impairment compared to sexually active HC. Sexual health impairment in SSc was associated with dis-

Table 1.

Questionnaire: score range	SSc (n=47)	HC (n=47)	p-value	SSc SA (n=29)	HC SA (n=29)	p-value
FSFI :2(worst)-36 (best)	14.7 $\pm$ 1.6	25.7 $\pm$ 1.6	p<0.0001	20.6 $\pm$ 1.7	28.5 $\pm$ 1.4	p<0.0001
BISF-W:-16(worst)-75(best)	16.6 $\pm$ 2.5	31.0 $\pm$ 2.6	p=0.0002	25.7 $\pm$ 2.8	34.9 $\pm$ 2.3	p=0.0143
SQoL-F: 0(worst)-100(best)	53.5 $\pm$ 3.7	79.9 $\pm$ 3.1	p<0.0001	58.0 $\pm$ 5.0	84.5 $\pm$ 2.6	p<0.0001
PISQ-12: 0(best)-48(worst)	14.6 $\pm$ 0.9	8.4 $\pm$ 0.6	p<0.0001	13.6 $\pm$ 1.0	7.9 $\pm$ 0.7	p<0.0001
PFIQ7: 0(best)-300 (worst)	29.0 $\pm$ 6.2	7.9 $\pm$ 2.0	p=0.0075	15.5 $\pm$ 5.0	9.3 $\pm$ 2.8	ns

Abbreviations: FSFI: Female Sexual Function Index; BISF-W: Brief Index of Sexual Function for Women; SQoL-F: Sexual Quality of Life Questionnaire; PISQ-12: Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire short form; PFIQ7: Pelvic Floor Distress Inventory Questionnaire, SA: sexually active; ns: not significant

Table 2.

Parameter: score range	Correlated parameters	r	p-value
FIS (fatigue): 0(best)-160(worst)	FSFI (sexual function)	-0.446	p=0.0016
MAF (fatigue): 1(best)-50(worst)	BISF-W (sexual function)	-0.445	p=0.0016
	SQoL-F (sexual quality of life)	-0.415	p=0.0050
BDI-II (depression): 0(best)-63(worst)	FSFI	-0.485	p=0.0005
	BISF-W	-0.483	p=0.0005
	SQoL-F	-0.375	p=0.0119
	PIFQ-7 (pelvic floor function)	0.445	p=0.0017
HAP (physical activity): 0(worst)-94(best)	FSFI	0.412	p=0.0040
	BISF-W	0.398	p=0.0055
SHAQ (scleroderma health status): 0(best)-100(worst)	FSFI	-0.557	p<0.0001
	BISF-W	-0.505	p=0.0002
	PIFQ-7	0.429	p=0.0025
ESSG activity index: 0(best)-10 (worst)	PISQ-12 (pelvic floor function)	0.322	p=0.0400
Disease duration	PIFQ-7	0.361	p=0.0124

Abbreviations: FIS: Fatigue Impact Scale; MAF: Multidimensional Assessment of Fatigue; BDI-II: Beck's Depression Inventory II; HAP: Human Activity Profile; SHAQ: Scleroderma Health Assessment Questionnaire; ESSG: European Scleroderma Study Group