REFERENCE

- [1] Yoshifuji H. Clin Med Insights Circ Respir Pulm Med. 2016 Apr 3;9 (Suppl 1):141-6.

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SAT0269

THE IMPACT OF SMOKING ON NAILFOLD MICROANGIOPATHY AND AUTOANTIBODY STATUS IN MALE AND FEMALE PATIENTS WITH SYSTEMIC SCLEROSIS

Jacopo Ciaffai^{1,2}, Nina van Leeuwen¹, Jeska de Vries-Bouwstra¹, Thomas Huizinga¹. ¹Leiden University Medical Center, Rheumatology, Leiden, Netherlands; ²University of Modena and Reggio Emilia, Rheumatology, Modena, Italy

Background: Smoking is a risk factor for primary Raynaud's phenomenon and, in patients with systemic sclerosis (SSc), has detrimental effects on the intensity of peripheral microangiopathy⁽¹⁾. Two studies on SSc observed a lower prevalence of anti-topoisomerase I antibodies (ATA) in ever-smokers compared to never smokers^(2,3), but little is known about how the effect of smoking on autoantibody status differs in male and female patients.

Objectives: The aim of our study was to evaluate, in a cohort of SSc patients, the influence of smoking on nailfold videocapillaroscopy (NVC) patterns and autoantibody positivity, comparing findings between men and women.

Methods: We included 361 adult patients (279 women and 82 men) with SSc. At baseline NVC was performed and microvascular damage was qualitatively assessed based on normal findings, aspecific/secondary pattern, or distinct "early", "active", or "late" scleroderma patterns. Information about smoking status was collected, but data regarding duration and intensity were not available for all individuals, so patients were categorized as never smokers or ever smokers. The presence of SSc-specific ATA, anti-centromere (ACA), and anti-RNA polymerase III (ARA) antibodies was investigated at baseline. Chi-square was used to compare proportions and significance level was set at 0.05.

Results: No significant difference was observed in the qualitative assessment of microangiopathy between ever smokers and never smokers, nor in autoantibody positivity. Scleroderma patterns early, active, and late, were respectively present in 12%, 44% and 21% of ever-smokers, and 9%, 48%, and 29% of never-smokers. Equal proportions of NVC patterns were found also in the gender-based sub-cohorts. Regarding autoantibodies, 27% of women who never smoked were ATA positive compared to 11% of ever smokers ($p < 0.001$), while the opposite trend was observed in men, although not reaching statistical significance possibly due to the relatively small size of the male cohort.

Conclusion: In our large cohort of SSc patients, microangiopathy was not influenced by smoking status in male or female patients. The prevalence of ATA was, albeit not significantly, lower in ever smokers. Our finding is in accordance with previous studies^(2,3), but it is worth noting that this disparity is largely contributed by the statistically significant higher frequency of ATA positivity in women who never smoked, compared to ever smokers.

Table 1. microangiopathy pattern and autoantibody positivity in ever smokers and never smokers in all SSc patients and in gender-based sub-cohorts. ATA: anti-topoisomerase I, ACA: anti-centromere, ARA: anti-RNA polymerase III, NVC: nailfold videocapillaroscopy.

	All SSc patients			Men			Women		
	Ever smokers	Never smokers	p-value	Ever smokers	Never smokers	p-value	Ever smokers	Never smokers	p-value
n (%)	208 (58)	153 (42)		62 (76)	20 (24)		146 (52)	133 (48)	
NVC Pattern									
scleroderma early, n (%)	26 (12)	14 (9)	ns	5 (8)	0	ns	21 (14)	14 (10)	ns
scleroderma active, n (%)	91 (44)	73 (48)	ns	24 (39)	11 (55)	ns	67 (46)	62 (47)	ns
scleroderma late, n (%)	44 (21)	45 (29)	ns	13 (21)	5 (25)	ns	31 (21)	40 (30)	ns
normal, n (%)	4 (2)	0	ns	2 (3)	0	ns	2 (1)	0	ns
aspecific/secondary, n (%)	43 (21)	21 (14)	ns	15 (24)	3 (15)	ns	20 (14)	14 (10)	ns
Autoantibodies									
ATA, n (%)	41 (20)	40 (26)	ns	25 (40)	4 (20)	ns	16 (11)	36 (27)	<0.001
ACA, n (%)	90 (43)	66 (43)	ns	10 (16)	6 (30)	ns	80 (55)	60 (45)	ns
ARA, n (%)	11 (5)	5 (3)	ns	2 (3)	0	ns	9 (6)	5 (4)	ns

REFERENCES

- [1] Hudson M, et al. Cigarette smoking in patients with systemic sclerosis. Arthritis Rheum 2011 Jan;63(1):230-8
- [2] Chaudhary P, et al. Cigarette smoking is not a risk factor for systemic sclerosis. Arthritis Rheum 2011 Oct;63(10):3098-102
- [3] Jaeger VK et al. Brief Report: Smoking in Systemic Sclerosis: A Longitudinal European Scleroderma Trials and Research Group Study. Arthritis Rheumatol 2018 Nov;70(11):1829-1834

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SAT0270

COMPREHENSIVE ICF CORE SET AND ICF-BASED QUESTIONNAIRE ASSESSING ACTIVITIES AND PARTICIPATION IN PATIENTS WITH SYSTEMIC SCLEROSIS: THE SCISCF STUDY

Camille Daste¹, Agathe Papelard¹, Sophie Alami², Katherine Sanchez¹, Alexandra Roren¹, François Segretin¹, Marie-Martine Lefevre Colau¹, François Rannou¹, Luc Mouthon³, Serge Poiradeau¹, Christelle Nguyen¹. ¹Service de Rééducation et de Réadaptation de l'Appareil Locomoteur et des Pathologies du Rachis, hôpital Cochin, Paris, France; ²Cabinet d'Étude Interlis, Paris, France; ³Service de Médecine Interne, Centre de Référence Maladies Systémiques Auto-Immunes Rares d'Île-de-France, Paris, France

Background: Recent guidelines regarding systemic sclerosis (SSc) emphasized the need of measuring functioning along with organ-specific measures, pointing out the importance of patient-reported outcome measures (1). The International Classification of Functioning, Disability and Health (ICF) endorsed by the WHO in 2001 set a unified language covering all dimensions of human functioning, including body structures, body functions, activities and participation and environmental factors.

Objectives: To develop a comprehensive ICF core set for SSc and to conceive a patient-centered ICF-based questionnaire assessing activities and participation in patients with SSc.

Methods: The development of the ICF comprehensive core set followed 2 steps (2). In the first step, meaningful concepts related to SSc were collected using data source triangulation from patients (N=18), experts (N=10) and literature (N=174 articles). In the second step, concepts were linked to the best-matching ICF categories by 2 independent reviewers according to prespecified linking rules (3). Finally, patient-reported activities and participation categories of the comprehensive ICF core set were translated into understandable questions

Results: After linking concepts to ICF codes, 151 ICF categories were collected from focus groups, 22 from experts and 82 from literature. After fusion of the sources and removal of duplicates, the comprehensive ICF core set included 165 categories: 1 at the first level, 158 at the second level, 6 at the third level, with 50 categories on body functions, 15 on body structures, 53 on activities and participation and 47 on environmental factors. Patient-reported ICF categories on activities

Conclusion: We developed a comprehensive ICF core set that offers a conceptual framework for SSc patients' care and health policy. Using a patient-centered approach, we conceived a patient-centered ICF-based questionnaire, the Cochin Scleroderma ICF-65 questionnaire, assessing activities and participation in patients with SSc.

REFERENCES

- [1] Merkel PA, Clements PJ, Reveille JD, Suarez-Almazor ME, Valentini G, Furst DE, et al. Current status of outcome measure development for clinical trials in systemic sclerosis. Report from OMERACT 6. J Rheumatol. 2003;30(7):1630-47.
- [2] Selb M, Escorpizo R, Kostanjsek N, Stucki G, Ustun B, Cieza A. A guide on how to develop an International Classification of Functioning, Disability and Health Core Set. Eur J Phys Rehabil Med. 2015;51(1):105-17.
- [3] Cieza A, Geyh S, Chatterji S, Kostanjsek N, Ustun B, Stucki G. ICF linking rules: an update based on lessons learned. J Rehabil Med. 2005;37(4):212-8.

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