Results: SSc patients started to suffer of CP in younger ages compared to AR/CH cohort but patients suffering of CH have higher mean scores in all questionnaires compared to AR/SSc. CH patients, have higher mean score in SFMPQ-sensory and affectory. Hundred percent (100%) of AR patients suffered of chronic pain. They, generally, had higher scores than SSc patients with a prevalence of the affectory component. The 83.9% (67/75 pts) of SSc patients experienced chronic pain [SF-MPQ PRI: 6.25 ± 8.34 DS; SF-MPQ PPI: 1.69 ± 1.34 DS; BPI-fattore1: 13.37 ± 11.26 DS; VAS: 40.7 ± 29.6 DS; NRS: 4.08 ± 2.98 DS] and in a great majority (84%) that pain interfered with their working activities and social lifes. Fortyeight percent of SSc patients had digital ulcers and 41.3% had musculoskeletal involvement. Pain used to correlate with both of them [$p=0.004$; $p=0.041$]. In patients with DUs, affectory component of pain overuled on the sensory one

Conclusion: SSc patients frequently experience chronic pain and particularly those who have a history of active DUs and musculoskeletal involvement. By the way, it seems that the BPI questionnaire could be more suitable than VAS or NRS in assessing DUs' pain. Furthermore it provides useful information on the impact of CP on social life and work impairment. Otherwise, SF_MPQ allows clinicians to better discriminate affective or sensory components of pain.

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SAT0286

EVALUATION OF SWALLOWING ALTERATIONS IN PATIENTS WITH IDIOPATHIC INFLAMMATORY MYOPATHIES

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Background: Dysphagia represents a frequent and disabling symptom in patients with Idiopathic Inflammatory Myopathies (IIMs) and it has been recently included in the new ACR/EULAR classification criteria for IIMs. Despite the clinical relevance, dysphagia assessment in IIMs is not currently standardized and evaluation tools are highly variable between different centers. Functional Endoscopic Evaluation of Swallowing (FEES) is an exam that allows, by using nasal endoscopy, the direct evaluation of anatomic structures and swallowing abilities in different swallowing phase. In fact, FEES could help the identification of different problems leading to dysphagia occurrence and to related dysphagia problems. Thanks to these characteristics, FEES for ENT specialists is the gold standard technique for evaluating swallowing functions. However, no studies so far have investigated the role of FEES in the assessment of IIMs and we are completely lacking a semeiotic description of FEES findings in these patients.

Objectives: To provide the first semeiotic description of swallowing alterations evidenced by FEES in a cohort of IIMs patients.

Methods: We retrospectively reviewed the FEES findings of IIMs patients performed at our hospital.

Results: We enrolled 19 patients with a diagnosis of IIMs (10 patients were positive for a myositis specific antibody), of these 16 (84%) reported symptomatic dysphagia. We divided patients into 3 groups based on levels of peripheral muscle strength. Six patients (32%) had no clinical sign of active muscle disease (MRC scale 5, median CK 51 mU/ml, IQR 35-235), 5 patients (26%) had a mild reduction in muscle strength (MRC scale 4, median CK 76, IQR 54-220) and 8 patients (42%) showed a moderate-severe reduction in muscle strength (MRC scale ≤ 3 , media CK 1440, IQR 628-6180). The 67% of patients without muscle disease activity showed an impairment in the oral phase of swallowing for solids and the 33% for fluids; 33% had a reduction in the activation of the pharyngeal phase of swallowing for both fluids and solids; only 17% of patients showed any sign of penetration, aspiration or pharyngeal residue for both solids and fluids. In the group of patients with moderate

muscle activity, 80% of patients showed impairment in the oral phase of swallowing for solids and 40% for fluids; 60% had a reduction in the activation of the pharyngeal phase of swallowing for solids while 40% for fluids; 40% of patients showed signs of penetration, aspiration or pharyngeal residue for both solids and fluids. Finally, in the group of patients with severe muscle disease activity, 88% of patients showed an impairment in the oral phase of swallowing for solids and 50% for fluids; 63% had a reduction in the activation of the pharyngeal phase of swallowing for solids while 50% for fluids; 75% of patients showed signs of penetration, aspiration or pharyngeal residue for both solids and fluids. The 15% of all patients (3 cases, 1 from each group of muscle activity) showed a dysfunction in the upper esophageal sphincter. Of note, 3 patients (15%; 1 with moderate and 2 with severe muscle disease activity) required nutrition through nasogastric tube.

Figure 1: swallowing alteration for solids and fluids in patients divided by muscle disease activity: no signs of muscle disease activity (green), moderate muscle disease activity (blue) and severe muscle disease activity (red).

Conclusion: We showed that FEES study identified swallowing dysfunctions in both the oral and pharyngeal phases of swallowing. Swallowing dysfunctions were more prevalent in patients with greater muscle involvement; however, alterations were not rare also in patients with no clinical signs of muscle activity and, in particular, in the few patients without reported symptoms of dysphagia. FEES appears as a useful tool for the evaluation of dysphagia in IIMs.

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SAT0287

SERUM CYTOKINE PROFILE IDENTIFIES PATHOMECHANISM AND EFFICIENT BIOMARKERS OF DISEASE ACTIVITY AND PROGNOSIS IN INTERSTITIAL PNEUMONIA COMBINED WITH POLYMYOSITIS/ DERMATOMYOSITIS

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Background: Polymyositis (PM) and dermatomyositis (DM) are idiopathic inflammatory myopathies that mainly involve the muscles, skin, lungs, and heart. PM/DM are frequently complicated by interstitial lung disease (ILD) that causes increased mortality. Anti-aminoacyl tRNA synthetase (ARS) antibody and anti-melanoma differentiation-associated gene 5 (MDA5) antibody are associated with complications of ILD. Anti-ARS antibody-positive PM/DM-ILD responds well to immunosuppressive therapy and has a good short-term prognosis but a high rate of relapse over the long term. In contrast, anti-MDA5 antibody-positive PM/DM-ILD responds poorly to immunosuppressive therapy, and its prognosis is poor. Recently, a number of cytokines have been implicated in the pathomechanism and