the clinical utility of the antibody and help deciphering the pathogenesis of this complex disease.

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Disclosure of Interests: Ho SO: None declared, Tak Lung Victor Wong: None declared, Maryam Dastmalchi: None declared, Valerie Leclair: None declared, Fabricio Espinosa-Ortega: None declared, Ingrid E. Lundberg Grant/research support from: Dr. Lundberg has received honoraria from Bristol Myers Squibb and MedImmune and is currently receiving a research grant from Bristol Myers Squibb and from Astra Zeneca., Consultant for: She is a scientific advisor for Bristol Myers Squibb, and aTyr DOI: 10.1136/annrheumdis-2019-eular.8020

SAT0298 DIAGNOSIS OF SYSTEMIC SCLEROSIS: HOW AND WHEN

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Background: Systemic sclerosis (SSc) is a heterogeneous disease regarding its clinical expression, evolution and forms of presentation. In spite of the lack of a disease modifying therapy, there are effective treatment options to control complications such as pulmonary arterial hypertension (PAH), interstitial lung disease (ILD) or digital ulcers (DU). Early diagnosis is crucial and allows the physician to start these treatments as soon as possible. To know how and when we diagnose SSc and its clinical manifestations will help us to detect potential improvement areas.

Objectives: To study the main clinical manifestations that lead to diagnosis of SSc, the delay of the diagnosis after the beginning of the first symptom, and to analyze the role of the different clinical features in the diagnosis.

Methods: A retrospective and descriptive study was conducted, which included patients with SSc from our Rheumatology Department. Clinical data and specific autoantibodies profile (ACA, Scl-70, RNP) were recorded, paying special attention to the clinical manifestations that led to diagnosis. We classified them in eight categories: secondary Raynaud's phenomenon (SRP), digital ischemia or DU, musculoskeletal symptoms, skin induration, ILD, PAH, specific autoantibodies detection, and others. The date of starting of Raynaud's phenomenon (RP), of the first non-Raynaud symptom and the date when the diagnosis was established were registered. Analysis were conducted using STATA.

Results: The sample included 149 patients with SSc, meeting the 2013 ACR/EULAR criteria. RP appeared several years prior to the diagnosis (median of 3 years, IQR 0-8), and typically before the first non-Raynaud symptom. 141 out of 149 patients (94,6%) presented RP prior to the diagnosis. However, SRP was the manifestation that led to diagnosis in only 42/149 patients (41,6%), followed by skin induration (18,1%) and DU (12,7%). Surprisingly, 30/149 patients (20,1%) were diagnosed after the appearance of severe complications such as DU, ILD or PHA. Most patients started symptoms related to SSc several years before diagnosis (details in Table 1). 40/48 patients (83%) that were diagnosed due to SRP, presented abnormalities in nailfold capillaroscopy as well as specific autoantibodies (Table 2). Presenting telangiectasia, calcinosis, ILD or PAH was not associated with an early diagnosis, nor was ACA, Scl-70 or RNP positivity.

Conclusion: An early approach of RP with capillaroscopy and specific autoantibodies would avoid delays to SSc diagnosis, allowing a close follow-up and an early treatment if necessary. SSc must always be considered as a differential diagnosis in patients with DU, ILD or PHA. An adequate referral of patients from primary care physicians to rheumatologists, and a multidisciplinary approach with Vascular Surgery, Pneumology and Cardiology Units would advance the diagnosis of this complex and potentially severe disease.

Table 1.

CLINICAL MANIFESTATION THAT LEADS TO DIAGNOSIS	PACIENTS n (%)	YEARS FROM FIRST SYMPTOM TO DIAGNOSIS median (IQR)	YEARS FROM RAYNAUD'S PHENOMENON TO DIAGNOSIS median (IQR)
Secondary Raynaud's Phenomenon	62 (41,6)	3 (1-10)	3 (1-9)
Skin induration	27 (18,1)	1 (0-4)	1 (0-4)
Digital Ischemia/UD	19 (12,7)	2 (0-12)	2 (0-12)
Musculoskeletal symptoms	18 (12,1)	3 (0-6)	3,5 (0-6)
ILD	8 (5,3)	2,5 (1-4)	3 (0-4)
Specific autoantibodies	6 (4)	5,5 (4-9)	3 (0-9)
Others	6 (4)	5,5 (0-10)	5,5 (0-10)
PAH	3 (2)	35 (20-35)	35 (20-35)

Table 2.

PACIENTES WITH SECONDARY RAYNAUD'S PHENOMENON	n (%)
With abnormal capillaroscopy	48/59 (81)
...and only ACA+	36 (75)
...and only anti Scl-70+	3 (6,2)
...and only anti-RNP+	2 (4,1)
... and ACA+ and/or Scl70+ and/or anti-RNP+	40 (83,3)
... without autoantibodies	8 (16,6)

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.5040

SAT0299 PREVALENCE OF PERIPHERAL EOSINOPHILIA AND CLINICAL ASSOCIATIONS IN THAI SYSTEMIC SCLEROSIS PATIENTS

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Background: Eosinophilia has been reported in systemic sclerosis (SSc) and localized scleroderma, so it might be part of the immune response in the pathogenesis of the disease.

Objectives: To determine the prevalence and clinical associations with peripheral eosinophilia in Thai SSc patients.

Methods: A cross-sectional study was conducted among Thai adult SSc patients, followed up at the Scleroderma Clinic, Khon Kaen University, Thailand, between November 1, 2016 and November 30, 2017. We excluded patients who had clinical overlap with other connective tissue disease, coexisting with localized scleroderma, eosinophilic fasciitis, or eosinophilia myalgia syndrome, and other diseases that cause eosinophilia. Peripheral eosinophilia is defined when total eosinophil count (TEC) is greater than 500 cells/mm³. Clinical, laboratory tests for tissue parasite, cytokines, and others for evaluation the cause of eosinophilia were done on the study date.

Results: A total of 185 SSc patients were enrolled. Fifty-seven cases (10.1%) were peripheral eosinophilia of which 21 had the causes of eosinophilia identified by laboratory without clinical symptoms (viz., 9 adrenal insufficiency, 2 tuberculosis, and 10 parasitic infection). The total prevalence of the unknown causes of peripheral eosinophilia in SSc was 21.9% (95%CI 15.9-29.1) (36 of 164 cases). Five of the patients had TEC above 1500 cells/mm³. Of the 164 SSc patients, the majority (70.6%) had diffuse cutaneous SSc, and the female to male ratio was 2.3:1. The respective median age and median duration of the disease was 57.0 years (IQR 52.2-63.9) and 6.5 years (IQR 2.9-10.5). According to a multivariate analysis, being male and duration of disease increasing