sera with mixed AC pattern. Regarding the Tregs and Th17 cells, we identified a reduced percentage of the CD25+Tregs at a marginal trend towards significance with the patients with mixed AC pattern versus the group with simple AC pattern (5.9 [3.2 – 10.6] vs 11.2 [6.1 – 14.3]; p = 0.06).

Conclusion: Although the pathogenetic contribution of ANA in SSc remains unclear, ANA play an important role in the differential diagnosis, risk stratification and assessment of disease activity in SSc. Further research is warranted to clarify the interconnection between the disregulated Th17/Tregs axis and the production of high-high-tier specific ANA in SSc. In the future rheumatologists could benefit from ANA in order to apply the most accurate therapeutic strategy for each patient.

Disclosure of Interests: None declared


SAT0547 ULTRASONOGRAPHIC FOLLOW UP OF ENTHESOPHYTE GROWTH IN A CONSECUTIVE SERIES OF IBD PATIENTS

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Background: Previous studies have found an interconnection between inflammatory intestinal diseases (IBD), particularly Crohn disease (CD) and Ulcerative Colitis (UC), and spondylarthropathies.

Objectives: We prospectively evaluate the pattern and predictive factors of enthesophyte growth in a cohort of patients with IBD.

Methods: A total of 68 IBD consecutive patients (31 CD, 36 UC, 1 ID, M/F 37/31, mean age 40.2 ± 13.2 years, mean disease duration 107.5 ±129 months) were enrolled. Rheumatological examination included 66 peripheral joint count, MASES and Leeds entheseal indexes, BASDAI, BASFI and evaluation of spine mobility. US examination was done at baseline and at 24 months using an Esaote MyLabClass, 18-6 MHz linear multifrequency transducer both in B-mode and PD-mode. The follow-up sites were blindly evaluated bilaterally: lateral epicondyle of the humerus, distal quadrupital insertion at the patella, superior and inferior pole of the patella, Achilles tendon insertion, and plantar aponeurosis insertion. Quadriceps, patellar, Achilles and plantar fascia entheses were scored according to the 0-36 Glasgow Ultrasound Enthesitis Scoring System (GUESS) and power Doppler (PD). The presence of enthesophytes was scored dichotomously as present (+1) or absent (+0) for each site and summed up to generate the ARE score (ARES). Enthesophytes was also scored semiquantitatively in a 0-3 scale (0 = absent, 1 = minimal, 2 = discrete, 3 = massive) for each site and summed up to generate RES score (RESS).

Results: Eighteen patients showed no increase of the RESS, 13 pts had 1 point increase, 12 pts less than 4 and 25 pts more than 4 points increase of the RESS at the end of follow-up. Baseline factors associated with RESS progression were age > 50 years, male sex, BMI > 25, CRP > 0.50 mg/dl, and alcohol consumption. As far as the number of sites involved only 8 patients showed no increase of ARES, while 25 pts had ARES increased more than 4. Baseline factors predicting ARES increase were pre-existing presence of enthesophytes at quadriceps tendon insertion at superior patellar pole, age > 50 y, male sex, and alcohol consumption. Progression of ARES and RESS was not associated with type of IBD, use of corticosteroid, biological agents or immunosuppressive drugs nor with the concomitant presence of cutaneous psoriasis, smoke habit, diabetes, dyslipidemia.

Conclusion: US examination of selected entheseal area demonstrates the increase of number and size of enthesophytes during a 2 years follow-up of IBD patients. Alcohol consumption and the presence at baseline of enthesophytes are the most important predictive factors for RESS and ARES progression respectively.