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PRIMARY SJOGREN SYNDROME ASSOCIATED INTERSTITIAL LUNG DISEASE: FEATURES, TREATMENT AND OUTCOME OF A MONOCENTRIC COHORT
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Background: Primary Sjögren’s syndrome (pSS) is an autoimmune systemic disease characterized by lymphocytic infiltration of exocrine glands, mainly resulting in dysfunction of salivary and lacrimal glands and sym pathetic xerostomia and xerophthalmia. About one third of patients also present extra-glandular manifestations and among them, interstitial lung disease (ILD) is one of the most frequent, occurring in about 10–20% of patients. ILD is associated with an impaired quality of life and physical capacity and to a reduced 10-year survival. Despite it seems to become more frequently detected in late stages of the disease, some authors suggest that ILD can be diagnosed before pSS in 20% of cases. Main predictive factors of progression of pSS-ILD have not been clearly investigated in previous studies and no evidence-based treatment is defined for these patients.

Objectives: To describe the clinical and serologic features and the outcome of a monocentric cohort of pSS-ILD and the possible differences between patients treated or not with immunosuppressive treatment.

Methods: We retrospectively evaluated the 37 pSS-ILD patients followed at our Rheumatology Unit (male/female ratio 1/6.4, mean age 69.6±11.3 years, mean disease duration of pSS 5±5.2 years).

Among them, 18 patients (48.6%; group 1) underwent immunosuppressive treatment because of lung disease, namely mycophenolate mofetil (9 patients, 50%), cyclophosphamide (3, 16.7%), azathioprine (5, 27.8%), high dose steroids (1, 5.6%), while 19 patients were not treated (group 2).

Results: No significant differences were observed in regard of age, male/female ratio, and disease duration of ILD and pSS, while a significant difference was observed regarding the lung function of the 2 groups; the forced vital capacity (FVC) and the diffusion lung capacity of CO (DLCO) at baseline were significantly lower in the group 1 (FVC 78.6% vs 99.4% of predicted; p<0.008; DLCO 45.7% vs 56.9%; p=0.025; in group 1 and group 2, respectively). No significant difference was observed between baseline and follow-up for FVC and DLCO in both groups, regardless the immunosuppressive treatment (fig. 1). At the end of follow-up FVC increased, decreased and remained stable in 5.3±10.5; 56.2% and 16.7;7±55.6%, in group 1 and group 2, respectively; DLCO increased, decreased and remained stable in 10.5±21.1;68.4% of group 1, while remained stable or decreased in 61.1 and 38.9% of treated patients, respectively (fig. 1).

Conclusion: At our knowledge, few studies have investigated the features of pSS-ILD and the role of immunosuppressive drugs in these patients. Our data suggest that the decline of lung function is one of the most significant parameters to guide the prescription of immunosuppressive drugs, but no differences can be observed according to the treatment in term of effectiveness. However, no studies have investigated the correctness of this approach or the efficacy of the MMF or OFX in pSS-ILD. Our study is strongly limited by the retrospective design and the low number of patients evaluated, but these data set attention on this unmet need. Further prospective studies are mandatory to clarify the impact of ILD in pSS patients and the correct therapeutic approach.

REFERENCES

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HYPOGAMMAGLOBULINEMIA AND INFECTIONS IN RHEUMATOLOGIC PATIENTS TREATED WITH RITUXIMAB
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Background: Treatment with rituximab (RTX) for rheumatologic diseases may produce hypogammaglobulinemia (hypoglob) (1,2), and that way increase the risk to acquire certain infections (3,4). There are no established guidelines to evaluate and treat hypoglob in these patients. In our hospital, the percentage of patients who develop hypoglob and severe infections is unknown.

Objectives: To analyse the effect of RTX on immunoglobulin (lg) levels and to evaluate the severe infections and hepatitis B reactivations that could be related to this treatment.

Methods: This is a descriptive, retrospective study of patients followed up in the Rheumatology Unit of the Alicante General University Hospital (HGUA) who had received at least one course of RTX. Clinical characteristics and laboratory parameters were obtained from the electronic charts: type of disease, posology and total amount of RTX, lg levels before and after treatment with RTX, the concomitant treatment with disease-modifying drugs (DMDs), hepatitis B virus’s (HBV) reactivations and infections that required hospitalization. Hypoglob was assessed when IgG < 750 mg/dl, and severe hypoglob if IgG < 450 mg/dl. The association of hypoglob with disease and treatment’s aspects was studied by t-Student, U-Mann-Whitney and Chi-2. Multiple logistic regression was conducted to study the independent risk factors associated with hypoglob. The study was approved by the Hospital Ethics Committee.

Results: Finally 106 patients were included, 85 women (80.2%) and 21 men (19.8%). The more frequent conditions were rheumatoid arthritis (47.2%), Sjögren syndrome (16%), Systemic Lupus Eritematosus (13.2%), vasculitis (6.6%) and other connective tissue diseases (10.4%). Characteristics of the sample are shown in table 1. A correct follow up of the Ig levels during the treatment was shown to be undergone in 87.7% of the cases. It was found that 35.8% of the patients presented hypoglob and 13.2% presented severe infections after receiving RTX. No HBV reactivations were found. Among the patients with hypoglob, 78.9% received concomitant treatment with other immunosuppressants (methotrexate 23.6%, leflunomide 23.6%); Hypoglob was more frequent in rheumatoid arthritis (44%), lupus (42.8%) and vasculitis (28.6%). Through simple logistic regression hypoglob during treatment was associated with the presence of previous hypoglob (p=0.025), higher doses received (p=0.01) and longer treatment (p=0.003). In the multiple logistic regression, only low levels of Ig before treatment turned out to be an independent risk factor for hypoglob during treatment (OR 6.86; IC 1.25-37.57). The IgM and IgA levels, but not the IgG levels were significantly lower in patients who have severe infections.

Initial treatment with RTX

Topical dosage (grams) 1700
Total dosage (grams) 12.7 ± 9.6
RTX posology 12.7 ± 9.6
Standard 79 (74.5%)
Single iv dose every 6 months 10 (9.4%)
On demand 11 (10.4%)
Ig levels followed up during treatment 79 (74.5%)

Disclosure of Interests: None declared