retrospectively included. The presence of a halo or occlusion was considered a positive CDU finding for GCA. In patients with PET-proven extra-cranial GCA, an axillary FDG uptake higher than liver uptake was considered positive. The reference was the clinical diagnosis (GCA or not) after 6 months.

Results: Of the 113 included patients, GCA was diagnosed in 41 and excluded in 72 patients at 6 months reference. PET-proven extra-cranial involvement was present in 20/41 GCA patients, of which 13 showed axillary involvement. An axillary halo was found in 8/13 of these patients, consistent with an increased FDG uptake. In 5/13, axillary involvement on PET was missed with axillary CDU (1/5 on steroids). However, in 4/5 of these an halo was found in the temporal arteries. Additionally, 6/20 patients with extra-cranial involvement did not show axillary involvement on both CDU and PET. All 6 had isolated involvement of a single artery on PET (2 aorta; 4 vertebral). CDU found a temporal halo in 3 of them. Overall, CDU of only the temporal arteries resulted in a sensitivity of 52% (95CI 35-67) and a specificity of 93% (95CI 84-97) for the reference diagnosis at 6 months. Adding CDU results of axillary arteries improved sensitivity to 71% (95CI 55-84), while specificity did not change. Although not systematically assessed, adding CDU assessment of the subclavian arteries improved sensitivity to 76% (95CI 59-87).

Conclusion: In case of an axillary halo no further FDG PET/CT scanning is required to diagnose extra-cranial GCA. In this study, investigation of both temporal and axillary arteries substantially increased the diagnostic performance of CDU. Furthermore, CDU and FDG PET arterial involvement is not always congruent, and occasionally arterial involvement is restricted to vessels not systematically assessed with CDU in our center. In patients in whom the axillary CDU is negative, a targeted CDU of selected vessels (e.g. subclavian, carotid or vertebral), or an FDG PET/CT is mandatory.

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Difficult to manage Sjögren's syndrome and Myositis

OP0212

DIGESTIVE INVOLVEMENT IN PATIENTS WITH PRIMARY SJÖGREN SYNDROME FROM THE SJÖGREN SPANISH REGISTRY

Sheila Melchor¹, Carlos Sánchez-Piedra², Monica Fernandez Castro³, Jose Luis Andreu³, Victor Martinez Taboada⁴, Alejandro Olive⁵, Jose Rosas⁶, Patricia Carreira¹, SjögrenSer Project. ¹Hospital Universitario 12 de Octubre, Rheumatology, Madrid, Spain; ²Unidad de Investigación SER, Madrid, Spain; ³Hospital Puerta de Hierro Majadahonda, Madrid, Spain; ⁴Hospital Marques de Valdecilla, Santander, Spain; ⁵Hospital Germans Trias i Pujol, Barcelona, Spain; ⁶Hospital Marina Baixa, Alicante, Spain

Background: Primary Sjögren's syndrome (pSS) is a systemic autoimmune disease characterized by lymphocytic infiltration of the exocrine glands. Among the extraglandular manifestations, digestive involvement (DI) is frequent, and may condition the quality of life of these patients. There are few studies that systematically analyze gastrointestinal involvement in pSS.

Objectives: To describe the prevalence of DI in patients with pSS included in SJÖGREN Spanish registry and the phenotype of these patients, and to analyze their association with other clinical manifestations, serological markers, activity index and treatments used.

Methods: Transversal multicenter study that includes all patients of SJÖGREN registry (patients who meet 2002 pSS classification criteria), a study conducted in 33 units of rheumatology in Spain between 2014-2016, which collected demographic and clinical and serological data (1). Patients were classified according to the presence of DI (that included esophagus, stomach, intestine, liver and pancreas). A descriptive analysis was done, with means and standard deviations, frequencies and proportions. Student t for quantitative variables and Chi2 for qualitative ones were performed to evaluate differences between groups. The association of DI with other variables was analyzed by bivariate and multivariate binomial logistic regression analysis. In the multivariate model all variables with p < 0.2 in the bivariate were included, and the effect of age and sex was controlled.

Results: From 437 patients included (95% women, median age of 58 years), 59 (13.5%) had some DI (21 (36%) chronic atrophic gastritis, 12 (20%) esophageal dysmotility, 3 (5%) lymphocytic colitis, 23 (39%) other). 54% of patients developed DI at the time of pSS diagnosis or later, and 45% before the diagnosis, with a mean age of 49 years at the onset of pSS symptoms. Patients with DI were older, both at diagnosis, onset of pSS symptoms and inclusion in the cohort, than those without it. There were no differences in the ESSDAI index between both groups. Comparison regarding clinical and serological characteristics is shown in Table 1. Patients with DI had more thyroid involvement and C3 hypocomplementemia. In addition, patients with DI had been treated more frequently with glucocorticoids and immunosuppressants.

In the multivariate analysis, DI was significantly associated with older age at diagnosis (OR 1.03 (1.00-1.05); p=.005), more C3 hypocomplementemia (OR 2.40 (1.10-5.26) p=.027) and absence of anti-Ro antibodies (OR 0.33 (0.12-0.87) p=.025).

Conclusion: In patients with pSS from the SJÖGREN cohort, the prevalence of digestive involvement is 13.5%. These patients are older at diagnosis, have more C3 hypocomplementemia and negative anti-Ro antibodies. These patients need more frequently glucocorticoids and immunosuppressants, suggesting a more severe disease phenotype.

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	WITH DI (n=59; 13.5%)	WITHOUT DI (n=378; 86%)	P value
Age symptoms pSS onset	49 ± 13	45 ± 13	0.006*
Age diagnosis pSS	54 ± 12	49 ± 12	0.008*
Age cohort inclusion	62 ± 10	58 ± 13	0.036*
sex	57F (96%), 2M	359F (95%), 19M	0.585
Glandular involvement	23 (39%)	119 (31%)	0.253
Lung involvement	9 (15%)	34 (9%)	0.121
Thyroid involvement	13 (22%)	66 (17%)	0.017*
Raynaud	17 (28%)	75 (19%)	0.116
anti-Ro antibodies	52 (88%)	357 (94%)	0.066
Hypocomplementemia C3	14 (25%)	51 (14%)	0.034*
Hypocomplementemia C4	12 (21%)	50 (14%)	0.131
Glucocorticoid treatment	36 (63%)	177 (47%)	0.026*
DMARD treatment	36 (64%)	180 (49%)	0.035*

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OP0213

MYOFASCIA-DOMINANT: INFLAMMATION DETECTED ON WHOLE BODY MRI PREDICTS RAPIDLY PROGRESSIVE INTERSTITIAL LUNG DISEASE IN PATIENTS WITH DERMATOMYOSITIS

Kohei Karino¹, Michihiro Kono, Michihito Kono, Yuichiro Fujieda, Masaru Kato, Toshiyuki Bohgaki, Olga Amengual, Kenji Oku, Shinsuke Yasuda, Tatsuya Atsumi. Department of Rheumatology, Endocrinology and Nephrology, Faculty of Medicine and Graduate School of Medicine, Hokkaido University, Sapporo, Japan

Background: Rapidly progressive interstitial lung disease (RPILD) is a major cause of death in patients with dermatomyositis (DM). Early diagnosis and aggressive immunosuppressive therapy are required in RPILD to improve the prognosis. Clinically amyopathic dermatomyositis (CADM) and anti-melanoma differentiation-associated gene 5 antibody are known as the risk factors for RPILD. However, 70% of the patients with CADM do not develop RPILD¹. Whole-body magnetic resonance imaging (WB-MRI) can detect inflammation of whole muscle and myofascia. Although recent studies have indicated that MRI could be