Objectives: We evaluated iRPF cases of a single institution cohort to describe the features of patients (pts) with iRPF.

Methods: Twenty-eight iRPF patients who were being followed in our outpatient clinic between 2009 and 2018 were reviewed retrospectively. The demographic characteristics, clinical and radiologic findings, medical and interventional therapies were retrospectively collected and reported.

Results: We evaluated the data of 28 patients (17M/11F). The mean age at the time of diagnosis was 53±10.57, median follow up was 46 (IQR:23-67) months. Fifteen (50%) patients were presented with abdominal-pain which was the most common initial complaint; 9 (32%) flank pain, 1 anuria, 1 nocturia, and 2 had nausea. Twenty-one patients had hydronephrosis (11 bilateral hydronephrosis, 5 right and 5 left hydronephrosis) at initial visit and one patient diagnosed while on temporary hemodialysis therapy. Laboratory tests showed that ESR was elevated in 15 of 23 cases in which it was available (65.2%), with a median value of 39 mm/h (IQR:17-88); CRP was elevated in 19 of 28 patients (68%), with median value 11 (IQR:5.5-46.5). Mean serum creatinine level was 1.14 mg/dl IQR (0.83-1.9). Tissue involvement was detected with computed tomography in 25 (89%) patients. The remaining 3 patients' involvement was located with ¹⁸F-fluorodeoxyglucose positron emission tomography (¹⁸F-FDG-PET). ¹⁸F-FDG-PET has been performed in 19 patients and 16 of them (84%) revealed tissue involvement of iRPF. Histopathological samples were available for further analysis in 8 cases and 5pts' findings were consistent with iRPF (storiform fibrosis and dense lymphoplasmacytic infiltration were observed) and of these 5 pts, 2 of them were classified as IgG4-related subtype. The remaining 3 pts were diagnosed with positive radiologic findings. Medical and interventional therapies are presented in Table 1. The mean initial oral prednisone dose was 45.5±13.8 mg/day. Prednisone was discontinued in 4 patients after remission and for the remaining 23 pts; 12 pts' prednisone was tapered <5 mg/day at mean 9 (IQR:6.7-22.5) months. One patient diagnosed AML-M2 during the follow-up and had allogeneic stem cell transplantation. Final median values of ESR and CRP were 10 mm/h (IQR:4.7-17.7) and 4.4 mg/l (1.9-7.7), respectively (p= 0.001 and p=0.002). Final median serum creatinine level was 1.03 (IQR:0.78-1.28) (p=0.2). Thirteen pts (46) were treated successfully with Rituximab who were not responded initial prednisone therapy. Twenty-one pts had ureteral stents and 11 of them are stent free at the final visit. Two pts had ureterolysis but the procedure was failed in one patient. None of the pts was deceased on the follow-up.

Conclusion: Steroids are the mainstay treatment for iRPF and steroid resistant cases could be treated with rituximab rescue therapy. Prompt interventional approaches are valuable bridging therapies for pts who presented with hydronephrosis. Imaging modalities add great value on the diagnose of iRPF.

. Types of medical and interventional therapy

Types of medical therapy	n, (%)
Glucocorticoid	27(96.5)
Glucocorticoid only	3 (10.5)
Tamoxifen	8 (28)
Azathioprine	8 (28)
Cyclophosphamide	1 (3.5)
Methotrexate	10(35)
Rituximab	13(46)
Mycophenolate Mofetil	1 (3.5)
Types of interventional therapy	n, (%)
Left ureteral stents	15(53.5)
Right ureteral stents	16(57)
Right nephrostomy	4 (14)
Left nephrostomy	2 (7)
Ureterolysis	2 (7)
Temporary Hemodialysis	1 (3.5)

Disclosure of Interests: None declared

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AB1098

COMPARISON OF THE PERFORMANCE OF CLASSIFICATION/DIAGNOSTIC CRITERIA FOR POLYMYALGIA RHEUMATICA. SINGLE CENTERSTUDY OF 100 PATIENTS

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Background: Polymyalgia rheumatica (PMR) diagnosis is based on the combination of shoulder and pelvic girdle pain associated with elevated

acute phase reactants. Traditionally, Bird et al.¹ and Chuang et al.² criteria have been used for establishing PMR diagnosis. In 2012 an international working group developed new European League Against Rheumatism (EULAR)/American College of Rheumatology (ACR) classification criteria for PMR.³

Objectives: a) To compare the performance of Bird et al., Chuang et al. and 2012 EULAR/ACR classification criteria for PMR in a single-center study. b) To describe the characteristics of the patients excluded by these criteria.

Methods: We included 100 patients with new-onset PMR who were consecutively diagnosed over a 7-year period by experienced rheumatologists from a single center. PMR diagnosis was confirmed during a prospective 24-months follow-up after excluding other mimicking conditions. Rheumatoid factor (RF) and anticitrullinated protein antibodies (ACPA) were determined in all patients. Subjects were classified by each of the three different criteria.

TABLE 1. 2012 ACR/EULAR CLASSIFICATION CRITERIA

Age at onset ≥ 50 years (required)	94/100	94%
Bilateral shoulder aching (required)	89/100	89%
Abnormal CRP and/or ESR (required)	96/100	96%
Morning stiffness duration > 45 min (2 points)	54/100	54%
Hip pain or limited range of motion (1 point)	90/100	90%
Absence of RF or ACPA (2 points)	100/100	100%
Absence of other joint involvement (1 point)	95/100	95%
Required for classification: score of 4 or more	84/100	84%

TABLE 2. CHUANG ET AL. CRITERIA (1982)

Age at onset ≥ 50 years (required)	94/100	94%
ESR ≥ 40 mm/hr	96/100	96%
Bilateral aching for ≥ 1 month involving two of the following areas:		
- Neck	47/100	47%
- Shoulders or proximal regions of the arms	89/100	89%
- Hips or proximal aspects of the thighs	90/100	90%
Exclusion of all other diagnosis of mimicking entities	100/100	100%
All criteria are required for classification	94/100	94%

TABLE 3. BIRD/WOOD CRITERIA (1979)

Age at onset > 65 years	59/100	59%
ESR > 40 mm/hr	96/100	96%
Bilateral shoulder pain/stiffness	89/100	89%
Duration onset < 2 weeks	77/100	77%
Stiffness > 1 h	54/100	54%
Depression and/or weight loss	16/100	16%
Bilateral upper arm tenderness	89/100	89%
Probable: 3 or more	96/100	96%

Results: We studied 100 patients (61 women/39 men); mean age 67.1 ± 10.2 years. 96% of the patients fulfilled Bird et al. criteria, 94% fulfilled Chuang et al. criteria and 84% of the patients fulfilled 2012 EULAR/ACR criteria (TABLE 1, 2 and 3). We assessed the characteristics of the 16 patients who did not fulfilled 2012 EULAR/ACR criteria: 6 of them were under 50 years of age (range age 43-48 years). Another 10 patients did not complain of pain/stiffness in the shoulder girdle at any time. However, they had typical inflammatory pain involving the pelvic girdle and elevated acute phase reactants.

Conclusion: In our single-center experience we found that 2012 EULAR/ACR criteria classified most of our patients. However, patients who presented predominant pelvic girdle affection and those who were under 50 years old despite showing all the rest of clinical and analytical required criteria were excluded. Some of these patients did fulfill Bird and/or Chuang criteria.

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AB1099

CHAGAS DISEASE REACTIVATION IN THE RHEUMATOLOGIC IMMUNOSUPPRESSED PATIENT. IS IT NO LONGER AN ORPHAN DISEASE?

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Background: Chagas' disease (CD) is an endemic and neglected infection in Latin America. Due to international human migration, it has become a worldwide issue. Scarce evidence is published regarding its behavior in rheumatic diseases (RD) with rheumatologic treatments (RT).

Objectives: To screen and follow up patients with CD under RT. To detect clinical and serological reactivation.

Methods: A systematic screening was conducted between January 2018 and January 2019 in a third-level Hospital in Argentina. Patients with CD and concomitant RD under RT were included. Assessments were done before and after RT. A direct (Strout) and indirect method (Polymerase chain reaction-PCR) were performed in order to detect parasitemia, levels of antibodies were evaluated by three techniques. Clinical, infectological and cardiologic features were examined. Everything was assessed in, at least, two opportunities, separated by a minimum of one month. If treatment was modified or clinical condition changed, all the evaluations were repeated as before. In case of reactivation, specific treatment was indicated and follow up controls were stricter.

Results: 38 patients were identified. RD: Rheumatoid Arthritis: 22 (57.9%), Systemic lupus erythematosus: 4 (10.5%), Systemic Sclerosis: 3 (7.9%), Vasculitis: 2 (5.3%), Psoriatic Arthritis: 1 (2.6%), others: 6 (15.8%). RT: classic, synthetic and biological disease-modifying antirheumatic drugs, cyclophosphamide and corticosteroids.

Two reactivations were detected with both direct and indirect methods, with a significant title antibody increment and consistent clinical signs and symptoms. Cardiologic abnormalities were found. A 64-years old lady with Microscopic Polyangiitis, under prednisone 60 mg/day and a 57-years old lady with Systemic Lupus Erythematosus under hydroxychloroquine and prednisone 40 mg/day, who happen to be sisters. They did not have other treatments. Both of them developed high fever, myalgias, arthralgias and asthenia. Other infections were ruled out. They received Benznidazole and Nifurtimox respectively. After one-week treatment, Strout and PCR became negative and antibodies decreased, with remarkable clinical improvement.

Conclusion: Two patients with parasitemia and concomitant symptoms were detected, after high doses of corticosteroids. Because they were sisters, a genetic background would also play a role. Parasite's screening before starting immunosuppression and its follow-up during treatment in search of reactivation should be integrated to rheumatology daily practice in endemic countries. It should also be taken into account in patients from non-endemic countries that have an epidemiological nexus. CD specific antibodies determination, Strout and PCR are economic and practical techniques, although they require qualified personnel and equipment. In areas with high prevalence of CD, the benefits of this measures would outweigh costs. A more advanced study should be performed to extend our knowledge.

Disclosure of Interests: None declared

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AB1100

PREVALENCE OF SARCOPENIA IN ECUADORIAN POPULATION BASED ON SCREENING AND DIAGNOSTIC TOOLS

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Background: Sarcopenia is defined as an abnormal loss of muscle mass associated with aging. It has been validated that sarcopenia can predict functional deterioration.

Objectives: The purpose of this study is to determine the diagnosis of sarcopenia by conventional methods and gold standard.

Methods: Prospective observational study of patients attending a rheumatology center, to whom anthropometric and densitometric measurements were taken in order to determine sarcopenia.

Results: A total of 110 patients were studied, from which 91% were women and 9% men. 66% presented sarcopenia by means of the gold standard test (DXA). The mean age was 65.80±9.84 [44-89]. The mean age for women was 66.2±9.9 [44-86] and the average age of menopause was 46.08±8.53 and 63% were found to have sarcopenia. In men, the mean age was 73.3±13.8 [63-89] and 30% had sarcopenia.

Anthropometric measures were determined. The mean body mass index was 26.58±4.67, which corresponds to overweight. Three tests were performed in addition to the gold standard. The average gait speed test was 1.12±0.74 seconds and 45% were positive for sarcopenia. The mean of the muscle strength test (dynamometer) was 19.33± 9.52 and 63% had sarcopenia. The mean of the SARC-F screening questionnaire was 3.02±2.24 and 22% were positive for sarcopenia. According to the measurement of muscle mass by DXA, the mean appendicular skeletal muscle mass (ASMM) was 16.08±3.52, ASMM index 6.77±1.12 and the total skeletal muscle was 21.39±4.68. Men presented a higher muscle mass index compared to women [7.82±1.93 vs. 6.66±0.95]. When grouping patients by BMI, sarcopenia was present in all of the patients with low weight, 88% in the ideal weight group, 67% in the overweight group and 25% in the obesity group. A statistically significant relationship was found between sarcopenia and sex [0.01], weight and height [<0.001], gait test [0.04], muscle strength test [<0.001] and DXA [<0.001]. In addition, the sensitivity and specificity of the tests were determined. SARC-F had a 15% sensitivity and a 9% specificity, with a positive predictive value of 74% and a negative predictive value of 37%. The gait speed test 24% sensitivity and 38% specificity, with a positive predictive value of 57% and negative predictive value of 27%. The muscle strength test had a 78% sensitivity and 65% specificity, with a positive predictive value of 84% and negative predictive value of 96% (Figure 1).

Abstract AB1100 Figure 1. Statistical measures of sarcopenia's diagnostic tools.

Conclusion: This is the first study of determination of Sarcopenia in a Rheumatology Center in the city of Guayaquil. 66% of the studied population presented sarcopenia. It is evident that conventional methods may determine a diagnosis, however, a definitive diagnosis can be established by DEXA. Because Sarcopenia is a multidisciplinary entity, more studies are needed to determine the usefulness of the conventional methods.

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