Objective: In the current study we aimed to identify the prevalence of the patients using CAM therapies and the factors associated with CAM usage among the patients with FMF. 

Methods: One hundred and sixty-five patients were included in the study. Data regarding demographic, social and clinical characteristics were obtained from the patients. The patients were asked whether they were using any type of CAM and if they had suffered harm and/or benefit. The treatment adherence of the patients was assessed using by Monksy Green Levine Scale (MGLS). The Beliefs About Medicines Questionnaire (BMQ-T) was used to assess patient’s beliefs about medicines.

Results: Fifty-six (33.9%) patients declared to use at least one CAM. The mean age of the patients was 34.1 ±12.7 years and the mean disease duration was 16.8±10.8 years. The mean dose of colchicine was 1.4±0.4 mg/day. Patients with concomitant disease and positive history of FMF in relatives had higher rates of using of CAM (p=0.011 and p=0.014 respectively). There was no statistically significance between age, sex, marital, socioeconomic and working status, difficulty of access to the treatment center, dose of colchicine, adverse events related to colchicine, attack frequency and disease severity of the patients and frequency of CAM using (p>0.05). The most frequently chosen types of CAM modalities were massage therapy (12.1%), imagining (9.7%), relaxation techniques (9.1%), cupping (9.1%) and natural products (9.1%). It is found that 42 (75.0%) of patients reported that they have suffered benefit from CAM. The mean duration of the using of CAM was 7.9 ±6.4 years. According to the BMQ-T, there was higher rate of concern about colchicine among patients that were using CAM (p=0.035) (Table 1). There was no statistically significance between compliance with colchicine treatment and using of CAM (p=0.313).

Table AB1107.  Table 1. Comparison of Beliefs about Medicines Questionnaire Scale of patients according to the use of CAM

<table>
<thead>
<tr>
<th>Variable</th>
<th>CAM user (n=56)</th>
<th>CAM non-user (n=109)</th>
<th>test</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMQ-T-Specific Necessity</td>
<td>4.0 (3.6-4.6)</td>
<td>4.0 (3.3-4.6)</td>
<td>-0.410</td>
<td>0.682</td>
</tr>
<tr>
<td>BMQ-T-Specific Concerns</td>
<td>3.2 (2.6-3.8)</td>
<td>2.8 (2.4-3.6)</td>
<td>-2.110</td>
<td>0.035</td>
</tr>
<tr>
<td>BMQ-T-General Overuse</td>
<td>2.5 (2.3-3.0)</td>
<td>2.5 (2.0-3.1)</td>
<td>-0.675</td>
<td>0.500</td>
</tr>
<tr>
<td>BMQ-T-General Harm</td>
<td>2.4 (2.0-3.0)</td>
<td>2.3 (2.0-3.0)</td>
<td>-0.858</td>
<td>0.391</td>
</tr>
</tbody>
</table>

CAM complementary and alternative medicine, BMQ-TBeliefs about Medicines Questionnaire Turkish translation, a Mann-Whitney U test:

Conclusion: Colchicine is the gold standard of treatment because of the known effect of colchicine treatment on the severity and frequency of FMF attacks and the risk of development of amyloidosis. Approximately one third of patients with FMF were using at least one of the CAM modalities in the current study. Concerns about colchicine treatment may have increased the tendency to use CAM therapies. On the other hand, patients should be informed that CAM therapies should not be an alternative to colchicine.

Disclosure of Interests: None declared


AB1108 COEXISTENCE OF SARCOIDOSIS AND CHRONIC INFLAMMATORY RHEUMATIC DISEASES

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Background: Sarcoidosis is a systemic granulomatous disease of unknown etiology, mediated by Th1 lymphocytes, characterized by bilateral hilar adenopathies, pulmonary infiltrates, ocular, articular and cutaneous involvement and histologically by noncaseating granulomas. Sarcoidosis can simulate many chronic rheumatic diseases but can also coexist with them, so there are doubts about whether there is a true association or is incidental. Likewise, the occurrence of sarcoidosis has been described as a paradoxical effect during treatment with biological drugs, especially with tumor necrosis factor antagonists possibly due to a dysregulation in the compensatory proinflammatory cascade related of TNF blockade.

Conclusion: Between sarcoidosis and Sjögren’s syndrome, systemic lupus
Characterization of patients with interstitial pneumonia with autoimmune features (IPAF) and its comparison with patients with scleroderma-related interstitial lung disease and with idiopathic fibrosis

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Background: Diffuse parenchymal pulmonary diseases, called interstitial lung diseases, are a heterogeneous group of disorders that are classified together due to clinical, radiographic, physiological or similar pathological manifestations. The diagnosis of idiopathic interstitial pneumonias requires the exclusion of known causes of interstitial pneumonia. Identifying an underlying etiology is important for clinical perspectives because it impacts prognosis and treatment. A recent number of studies has shown that many patients diagnosed as idiopathic interstitial pneumonia have clinical elements that suggest an underlying autoimmune process without meeting established diagnostic criteria for connective tissue disease. Our objectives were characterize the clinical findings of patients who meet the IPAF criteria and compare them with the clinical characteristics of patients with scleroderma-related interstitial lung disease and patients with idiopathic pulmonary fibrosis.

Methods: We retrospectively reviewed 254 patients hospitalized at the Hospital Clínico de La Universidad de Chile between January 2012 and June 2018 who had ICD-10 diagnosis of J.84 (Other respiratory diseases principally affecting the interstitium) and J99.1 (Respiratory disorders in other diffuse connective tissue disorders). The electronic medical record was reviewed retrospectively to extract pertinent data. We applied IPAF criteria to this 254 patients. We then characterized the clinical, serological and morphological features of the IPAF cohort and compared outcomes to other ILD cohorts: scleroderma-related interstitial lung disease and idiopathic pulmonary fibrosis (IPF).

Results: Of 254 patients screened, 17 patients met the IPAF criteria. Mean age was 60 years with a female predominance. The most frequent pattern by high-resolution computed tomography was NSIP present in 46.7%. The median of Forced Vital Capacity was 82%, and median of DLCO was 50%. 14 patients (82%) were treated with corticosteroids. 11 Patients (64%) used other immunosuppressant: 6 patients with azathioprine, 4 mycophenolate and 1 patient used cyclophosphamide. One patient received a lung transplant in IPAF cohort. We identified 2 deaths in IPAF cohort, 6 in sclerosis systemic and 30 in IPF cohort. IPAF cohort survival was worse than Scleroderma cohort and better than the IPF cohort. Conclusion: Our IPAF cohort is similar to the cohorts described in other studies, in relation to the age of diagnostic, female predominance and High-Resolution Computed Tomograph pattern. Also the trend in survival was similar to others previously described. Our study have limitations, the first one is related to the retrospective nature of the reviewed cohorts. Further prospective studies should be conducted for a more comprehensive evaluation of the evolution of these diseases and the impact of the treatments used.

REFERENCES


Disclosure of Interests: Karen Vergara: None declared, Silvana Saavedra: None declared, Felipe Reyes: None declared, Annelise Goecke Consultant for: Roche, Abbvie, Novartis, Pfizer, Paid instructor for: Roche, Speakers bureau: Roche, Novartis, Abbvie, Pfizer, Caterina Chesta: None declared, Sebastian Chavez: None declared