ROLE OF NEUTROPHIL TO LYMPHOCYTE RATIO, MONOCYTE TO LYMPHOCYTE RATIO, PLATELET TO LYMPHOCYTE RATIO, EOSINOFLPHIL TO LYMPHOCYTE RATIO AND BASOPHILE TO LYMPHOCYTE RATIO IN ASSESSING DISEASE ACTIVITY IN SPONDYLOARTHRITIS

Salomé García, Bruno Miguel Fernandes, Sara Ganhalo, Raquel Ferreira, Miguel Berandes, Geogina Tereso, Luísa Costa. Centro Hospitalar Universitário São João, Rheumatology, Porto, Portugal

Background: Neutrophil to lymphocyte ratio (NLR), monocyte to lymphocyte ratio (MLR), platelet to lymphocyte ratio (PLR), eosinophil to lymphocyte ratio (ELR) and basophile to lymphocyte ratio (BLR) have been associated with disease activity in Spondyloarthritis (SpA) and have been demonstrated to be promising systemic inflammation markers. NLR, MLR and PLR have been related to disease activity in Spondyloarthritis (SpA) but the results remain conflicting.

Objectives: We aim to determine the role of NLR, MLR, PLR, ELR and BLR in assessing disease activity in SpA.

Methods: Observational retrospective study was performed including consecutive patients with the diagnosis of SpA (according to ASAS classification criteria) followed at our Rheumatology Department. Demographic, clinical (including BASDAI, BASFI, ASDAS ESR and ASDAS CRP indices) and laboratorial data were collected from our national database at baseline and 6 months after initiation of a tumour necrosis factor inhibitor (TNFi). Correlations between variables were studied using Spearman correlation analysis and comparison between groups was performed using Wilcoxon test.

Results: The mean age of patients (n=297) was 41 years old (± 12), 160 (53.9%) were males with median disease duration of 12.4 (IQR 14.8) years. Two hundred and seven patients (69.7%) had Ankylosing Spondylitis, 26 (8.8%) Inflammatory Bowel Disease related SpA and 36 (12.1%) Undifferentiated SpA. Seventy-three (24.7%) patients were taking glucocorticoids and regarding conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs) use before starting the TNFi: 188 (63.3%) were not under any csDMARD and the remaining ones were under Sulfasalazine (70, 23.6%), Methotrexate (MTX) (21, 7.1%), Azathioprine (AZA) (5, 1.7%), Leflunomide (1, 0.3%) or associations between Sulfasalazine and AZA or MTX. Regarding the TNFi the majority of patients initiated Adalimumab (n=168, 28.6%), Golimumab (n=61, 25.6%) and Infliximab (n=57, 23.9%). The majority of patients had very high or high disease activity at baseline (59.6% and 31.3%, respectively); mean ASDAS CRP was 3.85 (± 0.99), mean ESR was 30.1 mm/h (± 21.9) and mean CRP was 36.9 mg/L (±113.9). The post-treatment mean ESR, ASDAS-CRP, ASDAS-ESR and BASDAI were significantly lower than mean baseline values, as they were also for NLR, MLR and PLR (p<0.01).

At the baseline evaluation, in anti-TNF naïve patients, NLR and MLR were positively correlated with the majority of parameters evaluated: ESR level (r=0.322, p<0.001), CRP level (r=0.379, p<0.001), ASDAS-CRP (r=0.255, p<0.01 respectively), ASDAS-ESR (r=0.261, p<0.01 respectively) and BASMI (r=0.169, p<0.01 respectively). There were no correlations between NLR and PLR.

Conclusion: At the evaluation 6 months after introducing a TNFi, we found less and weaker correlations than in naïve patients: NLR and PLR correlate positively with CRP (r=0.302, 0.315, p<0.01 respectively) and, reaching lower statistical significance, PLR correlate also with ASDAS-ESR (0.156, p<0.05); NLR with BASMI (0.184, p<0.05) and ESR (0.179, p<0.05); MLR with CRP (0.173, p<0.05). No correlations were found between those parameters and ELR or BLR.

MIOSESIS AUTOANTIBODIES PROFILE: DIAGNOSTIC RELEVANCE

Aleix García Dorta1, Yvelise Barrios3, Sonia Peña Montelongo1, Hernández Díaz Marta1, Andrea Monroy Calero1, Beatriz Rodríguez Lozano1, Andrés Franco2, Sagrario Bustabad1. 1Hospital Universitario de Canarias, Reumatology, La Laguna, Spain; 2Hospital Universitario de Canarias, Immunology, La Laguna, Spain

Background: The idiopathic inflammatory myopathies (IIM) are autoimmune systemic diseases that can affect several organs, but with special impact in the muscular-skeletal system. Autoimmunity is believed to have a role in its pathogenesis, with the presence of Autoantibodies (Abs) in more than 50% of the patients. Those Abs have been classified in Myositis-Specific Autoantibodies (MSA), with the Anti-Jo being the most frequent1-2; and MioSitis-Associated autoantibodies (MAA), also found in other connective tissue diseases. The availability of a multiplex analysis (Myositis Profile) has opened up new possibilities for the specific investigations of these Abs in the day-to-day clinical practice 1-2.

Objectives: To describe the clinical spectrum and the Ab results obtained from the myositis profile in patients (hospital admissions and ambulatory) of a tertiary university hospital.

Methods: Retrospective descriptive study (January to June 2018) of the results obtained in the myositis profile. The clinical characteristics of the sample is described in the context of the ELISA of the Ab results. We considered that applications of this Myositis Ab Profile were justified if they had EIPD and/or if they had 2 or more clinical and/or analytical characteristics associated with MAA. The Myositis Profiles consisted in a solid phase ELISA from EuroLINE M16 Antigens (M16-alfa, M16-beta, TIF gamma, MDAS, NXP2, SAE1, Ku, Pm-Scl100, Pm-Scl75, Jo-1, SRP, PL7, PL12, EJ, OJ, RO-52). Statistical analysis SPSS 17.0.

Results: A total of 165 applications were studied, 47% requested by Reumatology, 30% by Neurology and 9% by Internal Medicine. Justifications were: ILD (n=49), osteomuscular (n=30), connective diseases (n=28), Myositis (n=17), CK-NAC elevation (n=11), fibromyalgia (n=7) and others (n=22), 41 men and 59 women, Average Age 58 (± 15 years). We observe an increase of CK-NAC, GOT, GPT y LDH in 21%, 12%, 19% and 24% respectively. They refer muscle weakness in 18%, Raynaud’s phenomenon in 10%, arthritis in 15%, heliotrope eruption in 4%, Gottron’s papules in 1% and mechanics hand in 1%. Using the criteria specified in the method section, 52% of the applications were justified, being the 57% of them as ILD study. 32 (20%) of the 165 profiles were positive. 10 of the 49 patients with ILD had positive Abs (figure 1), 90% men of the 17 patients with myositis had positive Abs (figure 1), 63% women. 75% of them (6/8) were positive for MSA, the 65% were Anti-Jo (4/6). 1 patient with myositis associated with nopia (anti-CJ) of 3 of muscle biopsy were consistent with Mit, 73% of the 27 EMG were compatible. The 14 remaining patients had some positive Abs (figure 2): 7 connective tissue diseases studies, 4 osteomuscular pathology, 2 auto-inflammatory disease, 1 auto-inflammatory disease, 1 CK-NAC elevation and 1 with inflammatory bowel disease (IBD).

Conclusion: The use of this Ab profile as a protocol for patients with ILD without myositis clinical features, allowed us to classify a group of patients with autoimmun e diseases. In this group, the distribution by sex, 9 males and 1 woman is highlighted. We achieved the diagnosis on the 47% of patient with myositis clinical suspicion. The usefulness of myositis profile allowed us to detect antibodies which are not in other immunologic assays. Distribution by sex, 3 men and 5 women.
The implementation of this profile of auto-antibodies in patients without ILD and those without clinical and/or analytical characteristics associated with MII, did not provide any.

REFERENCES

Disclosure of Interests: None declared

AB1316 AGREEMENT BETWEEN SUBJECTIVE AND OBJECTIVE DEFINITIONS OF INACTIVE DISEASE IN CHILDREN WITH JUVENILE IDIOPATHIC ARTHRITIS

Gabriella Giancane1,2, Maria Francesca Gicchino1, Alessandra Alongi1, Chiara Campone1, Alessandro Consolaro1,2, Angelo Ravelli1,2, 1I.R.C.C.S. Giannina Gaslini, Genova, Italy; 2Università degli Studi di Genova, Genoa, Italy

Background: The choice of an appropriate definition of inactive disease (ID) is important because ID has been identified as the ideal therapeutic goal in the treat-to-target strategy in juvenile idiopathic arthritis (JIA). Several criteria for ID in JIA have been proposed, including Wallace 2004 and 2011 criteria and JADAS10 and clinical JADAS10 (cJADAS10) criteria. However, a recent study has shown that these criteria do not always identify the same group of patients. In addition, it is unknown whether and to what extent the formal definitions of ID agree with the subjective perception of disease remission by the physician and the parent.

Objectives: To investigate the concordance between current criteria for ID and subjective judgment of disease remission by physicians and parents in children with JIA.

Methods: We evaluated the clinical data of the last visits made in 669 children with JIA from March 2007 to December 2010 to identify all visits in which the caring physician and a parent judged subjectively and independently the child’s disease state as remission or non-remission and the parent declared whether he/she was satisfied or non-satisfied with current illness state (i.e., Parent Acceptable Symptom State, PASS). All visits judged subjectively by the physician and the parent as remission or judged in PASS by the parent were examined to identify those which met the Wallace 2004 and 2011 criteria and the JADAS10 and cJADAS10 criteria for ID. Visits which met both subjective and objective definitions were defined as concordant.

Results: Of the 246 visits in which the physician judged subjectively the disease state as remission, 34.6% and 26.7% met the 2004 and 2011 Wallace criteria, respectively, and 38.6% and 54.5% met the JADAS10 and cJADAS10 criteria for ID, respectively. (Figure 1) Of the 338 visits in which the parent judged subjectively the disease state as remission, 19.8% and 18% met the 2004 and 2011 Wallace criteria, respectively, and 34.9% and 48.8% met the JADAS10 and cJADAS10 criteria for ID, respectively. (Figure 2) In 76.4% of visits judged as remission by the physician, the parent provided the same evaluation. In 55.6% of visits judged as remission by the parent, the physician provided the same evaluation. Of 467 visits judged in PASS by the parent, the physician judged 17.6% and 14.8% met the 2004 and 2011 Wallace criteria, respectively, and 26.6% and 37.5% met the JADAS10 and cJADAS10 criteria for ID, respectively. Conclusion: The JADAS10 and cJADAS10 criteria for ID were more concordant with physician’s and parent’s subjective judgment of remission and with parent’s satisfaction with current illness state than Wallace criteria. The cJADAS10, which lacks the acute phase reactant, revealed the best concordance with both physician’s and parent’s subjective assessments. Physician-parent agreement was greater for remission judged by the physician than for remission judged by the parent.

Disclosure of Interests: Gabriella Giancane: None declared, Maria Francesca Gicchino: None declared, Alessandra Alongi: None declared, Chiara Campone: None declared, Alessandro Consolaro Grant/research support from: AbbVie, Pfizer, Angelo Ravelli Grant/research support from: Angelini, AbbVie, Bristol-Myers Squibb, Johnson & Johnson, Novartis, Pfizer, Reckitt Benkiser, and Roche, Consultant for: Angelini, AbbVie, Bristol-Myers Squibb, Johnson & Johnson, Novartis, Pfizer, Reckitt Benkiser, and Roche, Speakers bureau: Angelini, AbbVie, Bristol-Myers Squibb, Johnson & Johnson, Novartis, Pfizer, Reckitt Benkiser, and Roche

AB1317 WHAT IS A TOTAL KNEE OR TOTAL HIP ARTHROPLASTY FAILURE? A PATIENT PERSPECTIVE USING NOMINAL GROUPS

Jasvinder Singh1, Bella Mehta2, Serene Mirza2, Mark Figgie2, Peter Sculco2, Michael Parks2, Susan Goodman1, 1UAB School of Medicine, Birmingham, United States of America; 2Hospital for Special Surgery, Main Campus, New York, United States of America

Background: Total joint replacements (TJR) are commonly performed elective surgeries for people with end-stage arthritis. However, there is relative lack of qualitative research to define the patient perspective of what constitutes a failure of TJR.

Objectives: To discover when a TJR is considered a failure from the patient perspective using nominal group technique (NGT).

Methods: Patients who had undergone elective total hip (THR) and/or knee replacements (TKR) met in nominal groups to answer the question “When would you consider a knee or hip replacement to be a failure?” Patients competed questionnaires including demographics, pain, function, and satisfaction, independently listed their ideas and then ranked them with the group after clarification.

REFERENCES