recommended by the Canadian guidelines [3], which recommended "patients should undergo a physical examination which should be within normal limits except for tenderness on pressure of soft tissues however the specific tender point examination according to the 1990 ACR diagnostic criteria is not required to confirm a clinical diagnosis of fibromyalgia". Furthermore, it stated that "Fibromyalgia should be diagnosed as a clinical construct, without any confirmatory laboratory test, and with testing limited to simple blood testing including a full blood count, erythrocyte sedimentation rate, C-reactive protein, creatine kinase, and thyroid stimulating hormone. Any additional laboratory or radiographic testing should depend on the clinical evaluation in an individual patient that may suggest some other medical condition." However, many primary care physicians do not feel competent/confident to exclude other rheumatic conditions by physician examination.

Over the last decade, comorbid FM is increasingly recognized in many chronic musculoskeletal diseases including patients with inflammatory arthritis. A systematic review found that the prevalence of FM is 21%, 13% and 18% in RA, axSpA and PsA respectively [4]. Patients with comorbid FM have higher diseases activity score and more severe pain.

In 2016, the ACR diagnostic criteria for FM were modified and stated that "A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses." [5].

Conclusion: The motion that "FM is a diagnosis of exclusion" is no longer valid. FM should be a positive diagnosis and does not exclude other rheumatic diagnosis.

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SP0120 PERSONALISED TREATMENT FOR FIBROMYALGIA; THE IMPACT OF COMORBIDITIES

Serge Perrot. France, France

Background: The heterogeneity of the clinical presentation, the co-morbidities and the pathophysiologic mechanisms associated with fibromyalgia (FM), and the modest results on average for any therapy, call for a more individualized management strategy.

How to develop personalized treatment?

Individualized treatment can be developed on the basis of subgrouping of patients according to associated conditions and co-morbidities (mental health problems, chronic overlapping pain conditions, other somatic diseases) or on disease severity. Personalizing treatment needs to classify FM in specific subgroups. It can be proposed on the basis of clinical assessment (eg, degree of daily functioning), on co-morbidities or on dedicated questionnaires. Lastly, shared decision-making regarding treatment options can be directed according to patient preferences, co-morbidities, and availability in various health care settings.

What is currently recommended as a personalized approach?

The European League Against Rheumatism guidelines recommend a tailored approach directed by FM key symptoms (pain, sleep disorders, fatigue, depression, disability), whereas the German guidelines recommend management tailored to disease severity, with mild disease not requiring any specific treatment, and more severe disease requiring multicomponent therapy (combination of drug

treatment with aerobic exercise and psychological treatments). When indicated, treatments should follow a stepwise approach beginning with easily available therapies such as aerobic exercise and amitriptyline. We will present how successful application of a tailored treatment approach that is informed by individual patient characteristics should improve outcome of FM.

Key points: This presentation will presents suggestions for an individualized treatment strategy for FM patients on the basis of symptoms, disease severity and co-morbidities.

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FRIDAY, 14 JUNE 2019

13:30:00 – 15:00:00

Joint EULAR – EFIS: Combatting or harnessing ILC in the battle against autoimmunity

SP0121 DEBATE: ILC AS INNOCENT BYSTANDER

Mikael Ebbo. Hopital de la Timone, AP-HM, Aix-Marseille Université, Internal Medicine, Marseille, France

Innate lymphoid cells (ILC) are recently (10 years ago) described tissue-resident lymphoid populations [1]. They lack adaptive antigen receptor (generated by the recombination of genetic elements) and are innate counterparts of T lymphocytes. Indeed ILC1s, ILC2s, and ILC3s mirror CD4⁺ T helper (Th)1, Th2, and Th17 cells, respectively, in terms of transcription factor expression and cytokine production.

In this lecture, an overview of the different protective immunological functions of these helper ILC will be provided, in particular their role for maintenance of gut homeostasis, for control of parasitic, bacterial or viral infections, for anti-tumor immune responses, for metabolism, or for tissue repair mechanisms. The concept of ILC plasticity, which represents the capacity of these cells to change their phenotype and functional capacities in response to diverse microenvironment stimuli, will be also addressed. It directs the heterogeneity of these cells in the tissues, and may be important for their effective immune responses.

In this context, targeting ILC for therapeutic use, for example in the battle against autoimmune or inflammatory diseases in which they may also play roles [2], could be associated with deleterious consequences. However, recent data concerning patients with a profound and selective ILC deficiency and no susceptibility to disease will be also presented here. This last observation suggests that most protective functions mentioned above may be redundant and potentially dispensable for human health, at least in modern conditions of hygiene and medicine, when T cell and B cell functions are preserved.

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13:30:00 – 15:00:00

Optimizing the access to new treatments for RMD patients

SP0122 OPTIMIZING HOLISTIC TREATMENTS: THE CHALLENGE OF IMPLEMENTATION

Krysia Dziedzic. Keele University, School for Primary, Community and Social Care, Stoke on Trent, United Kingdom

International guidelines present recommendations for holistic care for RMDs, building upon best evidence. However, there is still a gap between what we know about best care and what we do to implement best care in our clinical services. Having EULAR guidelines alone (and multiple updates and revisions) is not enough to change complex systems. European funders are now investing in projects to accelerate the uptake of best care across multiple European partners.