The aim of this presentation is to provide insight into the pitfalls of imaging in diagnosing SpA, with a particular focus on false positives in imaging as well as the importance of interpretation of the clinical context.

Disclosure of Interests: None declared

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SP0195 IMAGING IN DISEASE AND TREATMENT MONITORING – DOES IT MATTER?

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Background: Imaging of the axial skeleton is a crucial step in classification and diagnosis of axial Spondyloarthritis. After diagnosis, patients with axSpA are being treated with non-steroidal anti-inflammatory drugs (NSAIDs) or with disease-modifying anti-rheumatic drug (bDMARD). Despite the fact, that the latter treatment is referred to as disease-modifying and modification of the disease is supposed to be relating to the objective course of the disease, as assessed by imaging, recommendations for monitoring of the course of axSpA by imaging are still lacking mostly due to the lack of data. Nevertheless, this aspect is mentioned in the treat-to-target principle for axSpA. Overall, earlier data have shown that the course of lesions documented by magnetic resonance imaging (MRI) is correlating well with other objective measures of changes of systemic inflammation such as c-reactive protein (CRP), than with patient-reported measures of disease activity. Similarly, conventional radiographs (CR) are being used for documenting of the development of structural changes over many years.

Objectives: The objective of this presentation is to show the current evidence of the possibilities of different imaging techniques used in axSpA for assessment of the course of the disease (both for the inflammatory and chronic changes) and give practical tips about when imaging would be advised for monitoring the disease course or where this can be avoided.

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SP0196 IS THERE ROOM FOR OTHER IMAGING MODALITIES BEYOND CONVENTIONAL X-RAYS AND MRI?

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Early diagnosis of spondyloarthritis is still tempting since objective measures to assess disease activity are often negative. MRI provides highly sensitive visualization of inflammation, but detection levels in early spondyloarthritis are varying. Another clinical temptation is early treatment evaluation of spondyloarthritis. An important outcome measure is therapeutic efficacy on bone formation in vertebral column and sacro-iliac joints. Conventional X-rays only allow for assessment of bone formation over a time span of at least 2 years. In this presentation, opportunities with new upcoming imaging techniques to address above mentioned clinical issues will be discussed in relation to longer existing imaging techniques.

Disclosure of Interests: None declared

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SATURDAY, 15 JUNE 2019

12:00:00 – 13:30:00

The lung in rheumatoid arthritis

SP0197 CASE 1 PRESENTER: EARLY RA WITH LUNG PROBLEMS IN THE CONTEXT OF BIOLOGICAL TREATMENT

Ana Milena Millán Arciniegas. Santa Creu i Sant Pau Hospital, Rheumatology, Barcelona, Spain

We present a 77-year-old male patient with a history of former smoker, arterial hypertension and dyslipidaemia, whose diagnosis of Rheumatoid Arthritis was made in July 2017 by arthritis of metacarpophalangeal joints, wrists and knees and positivity for anticyclic citrullinated peptide antibodies (ACPA) and rheumatoid

factor (RF). Treatment with Methotrexate and prednisone was started but the patient did not achieve adequate control of joint symptoms, so we decided to add Etanercept to the treatment. A good joint response was obtained but in a follow-up control he explained breathlessness with cough and low grade fever. The chest X-Ray was not conclusive and we decided to perform a high resolution computerized tomography (HRCT) scan. An interstitial involvement was detected and an accurate differential diagnosis was made.

Disclosure of Interests: None declared

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SP0198 CASE 1 DISCUSSANT: HOW TO DIFFERENTIATE ILD FROM OTHER CAUSES OF LUNG INVOLVEMENT IN RA

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The lung in Rheumatoid Arthritis (RA) can be affected by different manifestations and Interstitial Lung Disease (ILD) related to RA is one of the most devastating complications that we can find in the disease. The lung parenchyma involvement can be present with different patterns. As opposite with other forms of connective tissue diseases the usual interstitial pneumonia pattern (UIP) is more frequent than nonspecific interstitial pneumonia pattern (NSIP) in RA. Currently high-resolution computed tomography (HRCT) and pulmonary function test are the best tools to detect and to follow ILD in RA. Nevertheless, other lung involvements, infections and drug toxicity of nonbiological and biological disease-modifying anti-rheumatic drugs (DMARDs) can affect patients with rheumatoid arthritis and simulate ILD. To know which affection are present in our patients with interstitial lung compromise is crucial to proceed against the problem. Patient characteristics, clinical presentation, radiological distribution or bronchoalveolar lavage would be helpful to discriminate ILD from other causes of lung involvement. An individual and multidisciplinary approach is very important to do the best management in these patients.

Disclosure of Interests: None declared

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SP0199 CASE 2 DISCUSSANT: HOW TO TREAT DIFFICULT ILD

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Background: ILD frequently results in progressive and irreversible destruction of the lung through scarring. Prompt therapy can help rescue lung function and prevent subsequent respiratory decline. This case will demonstrate the challenges inherent in diagnosing and managing interstitial lung disease in the context of connective tissue disease

Objectives: To discuss typical presentation of CTD-ILD

Review challenge of making diagnosis and choosing best treatment.

Assess treatment options, duration of therapy and measurement of treatment response.

Conclusion: A range of therapeutic options exist for CTD-ILD albeit with a paucity of trial data to support best practice. Accurate diagnosis of systemic disease, paired with careful assessment and monitoring of the respiratory system are vital in ensuring optimal management. Intravenous therapy is often necessary in advanced disease or for disease which proves refractory to oral immunosuppression.

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