had non-extensive involvement (ACA: 2, ATA: 7, "other ANAs": 6) performing Goh et al score with the FVC correction. Extensive ILD was found among 18 patients (ACA: 4, ATA: 11, "other ANAs": 3). Despite the fact that ATA+ group was more likely to have an extensive involvement no statistical significance was met. About pulmonary function tests (PFT) the mean FVC was 98,45% on ACA group, whereas on ATA and other ANAs groups the mean FVC were 88,97% and 81,43% respectively. Statistical differences were found between first and third group. However this difference was not found when only patients with pulmonary involvement were analyzed.

Conclusion: In our cohort, ATA and other ANAs groups were more likely to develop pulmonary interstitial disease and to need immunosuppressant treatment. Although the prevalence of ILD among ACA+ was only 10%, 50% of them required, due to the functional impairment or extension, immunosuppressant treatment. In spite of the low ILD-ACA+ incidence this complication should be kept in mind and periodical screening and assessment must be carried out as in other autoantibodies profiles.

Disclosure of Interests: None declared

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Table 1. ACA ATA Other ANA[1]

Table 1	ACA	ATA	Other ANA
Patients, n (%)	60 (55,6)	22 (20,4)	26 (24,1)
Sex			
Female (%)	57 (95)	18 (81,8)	21 (80,8)
Male (%)	3 (5)	4 (18,2)	5 (19,2)
Age at diagnosis, median (years)	59	55	61,5
Smoke			
Active (%)	1,7	4,5	11,5
Former (%)	23,3	4,5	26,9
DIAGNOSIS			
lcSSc (%)	55 (91,7)	4 (18,2)	11 (42,3)
dcSSc (%)	4 (6,7)	17 (77,3)	11 (42,3)
Time from diagnosis to ILD, mean (months)	6	5	0
Death, n (%)	8 (57,2)	2 (14,2)	4 (28,6)
PCR, mean (DS)	4,69 (3,9)	5,25 (3,75)	8,08 (8,34)
VSG, median (mm/h)	18	20,5	21
PH (%)	23,7	18,2	19,2
GERD (%)	72,9	77,3	57,7
ILD, n (%)	6 (10)	18 (81,8)	9 (34,6)
FVC, mean (DS)	98,4 (18,5)	88,9 (21,7)	81,42 (22,8)
DLCO, mean (DS)	72,5 (20,4)	75,5 (35,9)	73,4 (20,7)

FRI0323

EVALUATION OF LIPID PROFILE AND ATHEROSCLEROSIS IN TREATMENT-NAÏVE PATIENTS DIAGNOSED WITH UNDIFFERENTIATED CONNECTIVE TISSUE DISEASE (UCTD)

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Background: Patients with UCTD cannot be definitely diagnosed with a well-characterized systemic rheumatic disease. These patients often exhibit one of several disease patterns, manifesting multiple nonspecific clinical or serologic abnormalities, sometimes of more than one defined rheumatic disorder.

Objectives: The aim of this study is to investigate lipid profile and atherosclerosis in UCTD patients.

Methods: This is a prospective, observational study which included 30 treatment-naïve UCTD patients. Thirty patients and 30 healthy matched-controls were compared for total cholesterol (TC), high-density lipoprotein cholesterol (HDL-c), low-density lipoprotein cholesterol (LDL-c) and triglycerides (TGs). Furthermore, in order to describe endothelial dysfunction and presence of atherosclerosis, we assessed intima-media thickness (IMT) of common carotid artery with the contribution of an experienced sonographer. We also measured Apolipoprotein A1 (ApoA1), Apolipoprotein B (ApoB), Apolipoprotein E (ApoE), Lipoprotein A (LpA), erythrocyte sedimentation rate (ESR), high-sensitivity C-reactive protein (HSCRP) and fibrinogen in the group of patients only.

Results: Thirty UCTD patients were studied. There were 11(36.7%) men, 19(63.3%) women and 7(23.3%) smokers. The mean (SD) age was 54.4

(13.1) years and disease duration was 17.3(10.4) years. All reported Raynaud's phenomenon, 22(73.3%) had esophagus disorders, 21(70%) had pulmonary fibrosis and 3(10%) pulmonary hypertension. Arthritis was present in a great majority of these patients (93%). The immunological evaluation of the patients showed that 4(13.3%) had positive anticardiolipin antibodies and 11(36.7%) had scl-70 (+).

The comparison of IMT between patients and matched-controls revealed an increased IMT in UCTD patients [0.82 (0.32) vs 0.6 (0.13) mm; p<0.001]. There was also a significant difference in mean (SD) TC [204.4(43.03) in patients vs 238(41.4) in controls; p value<0.004] with respective reduced levels of mean(SD) HDL in patients [50.6(9.5) vs 61.3 (13.3); p value<0.002]. No statistically significant difference was found for LDL-c and TGs.

These patients had mean (SD) ApoA1 146.9(27.6), ApoB 94.9(25.6), ApoE 42.1(10.7), LpA 12.8 (15.9), HSCRP 7.5(13.5), ESR 28.9 (22.6) and fibrinogen 422.9(101.3).

Conclusion: IMT measurement confirmed that UCTD patients are prone to endothelial dysfunction and consequently to atherosclerosis. Treatment-naïve patients had reduced TC levels in combination with low levels of HDL-c reflecting high disease activity. Control of the disease and initiation of specific therapy may induce an improved lipid profile.

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FRI0324

DISEASE ACTIVITY INDICES IN SYSTEMIC SCLEROSIS- WHICH TO USE IN DAILY PRACTICE?

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Background: Currently there is no fully validated index for assessing overall disease activity in patients with systemic sclerosis (SSc).

Objectives: To estimate the effect of disease activity as measured by 4 disease activity indices on the risk of subsequent organ damage in a EUSTAR center cohort.

Methods: Longitudinal observational study; European Systemic sclerosis study group disease activity index (EScSG DAI), revised EUSTAR disease activity index (r-EUSTAR DAI), 12 point activity index proposed by Minier (12point DAI) were calculated for all patients; the CRIS (The Combined Response Index for Systemic Sclerosis) only for patients included after 2016. Student t-test/Mann-Whitney test, chi-square test were used to evaluate differences across subgroups; Pearson's bivariate correlation/Spearman's rank correlation coefficient to evaluate the association between variables. The predictive value of various variables for major organ involvement was assessed by Roc curves and univariate regression.

Results: 91 patients were selected, 77 females (84.61%), 51,65(13,20) years old at diagnosis, 49,45% diffuse subset.

Disease activity scores were all higher in male patients and in patients with diffuse cutaneous involvement, digital ulcers(DU), lung fibrosis, scleroderma renal crisis (SRC), arrhythmias, muscle atrophy, gastric involvement, antitopoisomerase-1 positive, EScSG DAI correlated with forced vital capacity (FVC)(r=0.73,p<0.001), DLCO(r=0.68,p<0.001), DU(x2= 3.08, p=0.05), lung fibrosis(x2=10.90,p<0.0), systolic pulmonary arterial pressure (sPAP) (r=0.54,p<0.001), muscle atrophy (x2=11,58,p=0.001), diffuse subset (x2=11,46,p=0.001).

R- EUSTAR DAI correlated with FVC(r=0.6,p<0.001), DLCO(r=0.58, p<0.001), diffuse subset(x2=9,52,p<0.01), contractures(x2=11,23,p=0.001), muscle weakness(x2= 6.61,p=0.01), muscle atrophy (x2=10,19, p<0.001), SRC (x2=4,74, p=0.02) and sPAP(r=0.5,p<0.001).

12 point DAI correlated with FVC(r=0.57,p<0.001), DLCO(r=0.66,p<0.001) and sPAP(r=0.42,p<0.001).

EScSG predicted well lung fibrosis (AUC=0.79,p<0.001), DU (AUC=0.66, p<0.001), gastric involvement (AUC=0.73, p<0.01) and SRC (AUC=0.9, p=0.01). R-EUSTAR index also lung fibrosis (AUC=0.76,p<0.001), DU (AUC=0.82,p<0.01) and SRC (AUC=0.84,p=0.04).

12point DAI was a good predictor for lung fibrosis(AUC=0.74,p<0.01), DU (AUC=0.78,p=0.05), gastric involvement(AUC=0.76,p=0.01).

In the regression analysis, lung fibrosis(beta=0.5,95%CI=1,21-2,58,p<0.01), muscle atrophy (beta=1.49, 95%CI=1.02-2.19,p=0.03) and rhythm and conduction disturbances (beta=1.98, 95%CI=1.31-2.99,p<0.001) were independent predictors for disease activity evaluated by EScSG. For 12-EUSTAR DAI none of the evaluated parameters proved to independently contribute to disease activity. For 12point DAI items independently