tively after arthritis and inflammatory myopathy onset. Three (12%) patients were admitted to the Intensive Care Unit for Rapidly Progressive (RP) ILD and 2 died (respectively 2 months and 54 months after ILD onset), whereas the alive patient had 2 ICU admission for RP-ILD. Five (20%) patients, including the only 1 dismissed from ICU, needed home O₂ therapy. Ongoing and previous therapies are reported in figure 2.

Conclusion: We showed that the prognosis of IPAF is highly variable, with patients experiencing RP ILD, other slow progressive worsening of respiratory functions and other a substantially stable disease. Furthermore, we showed other findings, laboratory, clinical and instrumental, that could help clinicians in a better identification and stratification of IPAF patients. As a matter of fact, at present, IPAF appears as a generic term including very different conditions that can be further differentiated according to clinical and serological data.

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Figure 1. Antinuclear antibodies determination results

Figure 2. Ongoing (at last follow-up) and previous treatments

Disclosure of Interests: Emiliano Marasco: None declared, Federica Meloni: None declared, Giovanni Zanframundo: None declared, Adele Valentini: None declared, Valentina Morandi: None declared, Veronica Codullo: None declared, Lorenzo Volpiano: None declared, Claudia La Carruba: None declared, Francesca Motta: None declared, Carlomaurizio Montecucco Speakers bureau: AbbVie, Bristol-Myers Squibb, Celgene, Sanofi, Genzyme, Lilly, MSD, Pfizer, UCB, Lorenzo Cavagna: None declared

DOI: 10.1136/annrheumdis-2019-eular.2704

FRI0336 INCIDENCE OF IDIOPATHIC INFLAMMATORY MYOPATHIES (IIM) IN ADULTS IN FIFE, SCOTLAND, UK

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Background:

Objectives: To determine the Adult incidence of IIM in the Kingdom of Fife, Scotland. The Fife population is 370,000 and constitutes 6.8% of the Scottish Population (5,425,000). 98% of the Fife population is Caucasian. We also sought to characterise the incident IIM cases in terms of subtype and autoantibody profile.

Methods: All newly diagnosed Adult cases (≥ 18 years) of IIM between 01.03.17 and 30.11.18 were recorded (11.75 year period). The cases were identified by a search of the Fife Rheumatic Diseases Unit Database using IIM-specific ICD-10 codes. These were cross-referenced with a prospective personal database of IIM cases established by the Lead Author (JMCL) on 26.02.17. In addition a search of all Fife patients enrolled in the UKMYO-NET study was also performed. All patients with 'definite' or 'probable' IIM by the Bohan & Peter 1977 criteria; Clinically defined Inclusion Body Myositis (IBM) by the ENMC 2011 criteria; or other specific criteria in the

case of Clinically Amyopathic Dermatomyositis (CADM) and Immune-mediated Necrotising myopathy (IMNM) were included.

Results: 53 newly diagnosed Adult IIM cases were identified. 11 Dermatomyositis (DM) (3 NXP2; 2 Jo-1; 2 TIF1-G; 1 Mi-2; 3 Myositis-specific antibody (MSA) not tested). 4 Polymyositis (PM) (1 Jo-1; 1 MDA5; 1 MSA/Myositis-associated antibody (MAA) negative; 1 MSA not tested). 12 Anti-synthetase syndrome (8 Jo-1; 3 PL7; 1 PL12) and 3 patients with Jo-1 isolated Interstitial lung disease (ILD). 5 Overlap Connective tissue disease (CTD) : 2 Systemic Lupus Erythematosus; 2 Systemic sclerosis; 1 Mixed CTD. 5 Cancer-associated myositis (CAM) : 2 lung (1 NXP2 DM & 1 SRP PM); 1 ovarian (DM, MSA not tested); 1 Breast (DM, TIF1-G); 1 Prostate (DM, Mi-2). 5 CADM (2 MDA5; 1 TIF1-G; 1 NXP2; 1 MSA not tested). 4 IMNM (2 HMGCR; 1 HMGCR overlap with IBM; 1 SRP overlap with IBM who developed bladder cancer < 3 years after diagnosis). 4 sporadic IBM (2 cN1-A/Mup44 of which 1 overlap with Primary Sjogren's Syndrome; 2 MAA not tested).

Conclusion: The incidence of IIM in Fife, Scotland is 4.5 cases per year which equates to an annual incidence of 12.2 cases per million population. This is comparable with the incidence data published for Salford in the UK (17.6). However the IIM subtypes differed from Salford in that Fife has a much lower incidence of PM. 40/49 (82%) of Fife patients who were tested were found to be MSA positive.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8242

FRI0337 INCIDENCE AND PREVALENCE OF MYOSITIS ASSESSED BY MULTI-SOURCES CAPTURE-RECAPTURE METHODOLOGY

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Background: Precise epidemiology of myositis epidemiology remains largely unknown (1). Surveys based solely on administrative claims benefit from large case ascertainment but may be influenced by miscoding and misdiagnosing. The use of medical records with charts review benefit from accurate diagnosis but exhaustive ascertainment is difficult to achieve because numerous specialists are involved and cases may concern both inpatients and outpatients.

To overcome these difficulties we undertook a capture-recapture survey that takes advantage of a multi-sources case ascertainment to estimate the number of cases missed by any one source and to correct the prevalence rate (2).

Objectives: To assess the incidence and prevalence of myositis in Alsace, a region of eastern France.

Methods: Alsace, region of eastern France, is home to about 2 million inhabitants benefiting from high access to healthcare and a labialized referral center for myositis. Seeking care outside is uneasy because of peculiar geography. Myositis patients were retrieved through three separate sources: i) all general practitioners and community specialist ii) Muscle pathology center records, iii) all public and private hospitals records, vi) all public and private laboratory records. Incident and prevalent cases fulfilling the ACR/EULAR criteria for myositis were included.

Results: The responses to the questionnaires sent to the physicians (n=3452), yielded 105 potential myositis cases. All hospital centres contacted (n=13) participated in the study and 1335 potential myositis patients were recorded by this source. 263 potential myositis cases were identified through muscle pathology center records. 13 laboratories participated in the studies and 324 potential myositis patients were recorded by this source. We thus received 1863 records of suspected myositis after excluding duplicates within each sources. The thorough review of the corresponding medical charts is currently ongoing and at this stage 10% of the potential cases fulfilled the ACR/EULAR criteria for myositis.

Conclusion: This first study based on a multi-sources capture-recapture methodology and ACR/EULAR criteria is very likely to provide an accurate estimation of myositis epidemiology.

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