Capillary dimension has been evaluated in 2 studies, with no unequivocal results [3,4]. Corrado et al. found abnormal morphology to be more commonly associated with SSc-PAH [4]. No association was found between presence of haemorrhages and SSc-PAH [4]. Ricciari et al. found that NVC score and avascular area grade were more commonly associated with SSc-PAH [5]. Concerning qualitative assessment, severe NVC patterns have been unequivocally found to be more commonly associated with SSc-PAH [4,5].

Conclusion: This is the first systematic literature review to investigate the role of NVC in SSc-PAH using standardized definitions as proposed by the EULAR SG MC/RD. Unequivocal associations with incident SSc-PAH were found in longitudinal studies between capillary density, abnormal morphology and NVC pattern. Unequivocal associations with SSc-PAH were found in cross-sectional studies between capillary density and severe NVC pattern.

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FRI0346

PERFORMANCE OF THE 2017 EUROPEAN LEAGUE AGAINST RHEUMATISM/AMERICAN COLLEGE OF RHEUMATOLOGY (EULAR/ACR) CLASSIFICATION CRITERIA FOR ADULT IDIOPATHIC INFLAMMATORY MYOPATHIES IN A HONG KONG COHORT

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Background: The new classification criteria for idiopathic inflammatory myopathy (IIM) endorsed by the European League Against Rheumatism and American College of Rheumatology (EULAR/ACR) were published in 2017 [1]. However, the majority of the patients in the development cohort were Caucasians. External validation in other populations were advised. With the increasing availability and experience of myositis specific autoantibodies (MSAs) testing, the inclusion only anti-Jo-1 antibody is apparently insufficient.

Objectives: The objective of the study was to evaluate the performance of the 2017 EULAR/ACR classification criteria in a cohort of Hong Kong adult IIM patients. The secondary objectives included examining the level of agreement between the new criteria and the traditional criteria and assessing the effect of including other MSAs into the criteria.

Methods: This was a multi-centre retrospective cross-sectional study. Consecutive patients with a clinical diagnosis of IIMs and MSA tested seen in the rheumatology clinic or admitted to the rheumatology wards of the participating hospitals in Hong Kong up till August 2018 were recruited. Patients with juvenile onset myositis were excluded. Clinical parameters required by the two criteria will be collected by reviewing the medical records. A commercial line blot immunoassay kit (EUROIMMUN) was used to detect the MSAs.

Results: Two hundred and four patients with IIM were recruited. The mean age was 59.3 years. There was a female predominance of 76.5%. The subgroups of the patients were: polymyositis 40.7%, dermatomyositis 38.2%, clinically amyopathic dermatomyositis patients 21.1%. MSAs were detected in 59.3% of the patients with anti-Jo-1 antibody being the commonest (13.2%). The new 2017 EULAR/ACR Criteria could classify 96.1% of the patients as having definite or probable IIM. The Bohan and Peter criteria could only classify 76.0% of the patients. When combining with the Sontheimer's criteria for CADM, 93.1% of the patients could be classified. The percentage agreement of the new and the Bohan and Peter criteria also increased from 77.0% to 93.1% when the latter was supplemented by the Sontheimer's criteria. If the presence of any MSAs is considered one of the criteria, the performance of the 2017 criteria improved to 97.5% while the combined Bohan and Peter/Sontheimer's criteria to 96.1%. However, the new criteria still failed to highlight the important subtype of IIM associated with anti-MDA5 autoantibody.

Conclusion: In a population with a significant proportion of CADM patients, the new 2017 EULAR/ACR classification criteria outperformed the old criteria. Finally, a clinico-serological criteria for "anti-MDA5 syndrome" is proposed in which a patient must have positive serologic testing for an anti-MDA5 autoantibody, plus one of the following conditions:

myositis by the new EULAR/ACR criteria, interstitial lung disease or typical rash (skin ulceration, palmer papules).

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FRI0347

TUBERCULIN SKIN TEST FOR DETECTION OF TUBERCULOSIS IN SYSTEMIC SCLEROSIS

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Background: The tuberculin skin test (TST) is a screening tool for detection of occult or remote tuberculosis infection. Although skin tightness is a classic manifestation in systemic sclerosis (SSc), there are no reports vis-à-vis any limitation of the TST in SSc patients nor a definition on the cut-off for a positive TST test size for a diagnosis of tuberculosis.

Objectives: Our aims were to determine (a) the indurated reaction size of the TST; (b) the cut-off size for the indurated TST; and, (c) the sensitivity and specificity of the test for the diagnosis of tuberculosis in SSc patients.

Methods: A cross-sectional study was conducted among Thai adult SSc patients, followed up at the Scleroderma Clinic, Khon Kaen University, Thailand between November 1, 2016 and November 30, 2017. The TST was performed using 0.1 ml purified protein derivatives (PPD) injected intradermally (Figure 1), and interpreted 72 hours after testing.

Results: A total of 168 SSc patients were enrolled (female to male ratio = 1.8:1). The median age and duration of disease was 57.2 and 6.4 years, respectively. The majority (71.8%) was the diffuse cutaneous SSc subset. Seventeen cases (10.1%) were defined as tuberculosis infection. All of the patients had a history of BCG vaccination at birth. An indurated skin reaction size TST of 20 U/L had a high specificity for tuberculosis (99.3%: 95%CI 96.4-100) (Kappa 0.86; p=0.03). The modified Rodnan skin score (mRSS) had a significant negative correlation with the indurated skin reaction size (Rho -0.23; p=0.003). While other clinical parameters—such as BMI, SSc subset, serum albumin level, steroid or immunosuppressant use—were not correlated with the TST result (p=0.06, 0.14, 0.09, 0.23 and 0.89, respectively).

Conclusion: Indurated skin ≥ 20 mm indicated a high specificity for tuberculosis infection in SSc patients with history of BCG vaccination. The high mRSS resulted in a smaller skin reaction size when using the TST. The TST is thus less useful as a diagnostic tool for tuberculosis among SSc patients, especially among those with severe skin tightness.

Figure 1. Tuberculin skin test in a systemic sclerosis patient

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