mineral content (BMC), and bone mineral density (BMD) in seven body areas (head, upper limbs, lower limbs, trunk, ribs, pelvis, pelvis). Sarcopenia was diagnosed in patients with reduced skeletal muscle mass (RSM) below 5.45 Kg/m² for females and 7.25 Kg/m² for males (6). Statistical analysis was performed by non Parametric tests.

Results: The mean age of patients was 64±11 years, mean disease duration 19.2±7.6 years, mean Rodnan skin score (mRSS) 11.5±9.3, and fracture by FRAX determined in accordance to WHO criteria. All patients were interviewed by X-ray absorptiometry (DXA, Hologic 4500A). BMD decreasing grade was in lumbar spine (LS), femoral neck (FN) and total hip (TH) by dual energy fractures (mean age 53±14 yrs). Bone mineral density (BMD) was measured at (mean age 51±13 yrs), among them 107 postmenopausal, and 31 men. 

Methods: 191 patients with SSc were enrolled in the study: 160 women and 31 men. 160 women with SSc. There was no difference between the groups, but sarcopenic patients presented a statistically significant lower BMD (p=0.02).

Conclusion: This study demonstrates in SSc patients a relationship between a more severe microvascular damage (“Late” SSc pattern) and the body composition, characterized by lower weight, total lean mass, bone mineral content and sarcopenia, but no significant variation in total fat mass. These clinical conditions seem not to be associated with severity of skin involvement and/or disease duration.

REFERENCE:

Disclosure of Interests: None declared

THE FREQUENCY OF LOW MINERAL DENSITY, FALLS AND FRACTURES IN PATIENTS WITH SYSTEMIC SCLEROSIS
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Background: Systemic sclerosis (SSc) is a severe connective tissue disorder causing vascular, immune, and fibroblastic changes in the skin and internal organs. Patients with SSc may have an increased risk of osteoporosis (OP) and fractures due to a chronic inflammatory state, latent malabsorption or malnutrition, and immobilization, and use of corticosteroid therapy.

Objectives: to determine the frequency of low mineral density, falls, low energy fractures and 10-year probability of new fracture in patients with SSc.

Methods: 191 patients with SSc were enrolled in the study: 160 women (mean age 51±13 yrs), among them 107 postmenopausal, and 31 men (mean age 53±14 yrs). Bone mineral density (BMD) was measured at lumbar spine (LS), femoral neck (FN) and total hip (TH) by dual energy X-ray absorptiometry (DXA, Hologic 4500A). BMD decreasing grade was in LS (3%), FN (23%) and TH (25%). Reduced BMD was associated with a higher risk of falls and low energy fractures more than 2 times higher than patients with normal BMD (OR 2.93 [95% CI 1.11; 8.01], p=0.016 and OR 2.58 [95% CI 1.04; 6.6], p=0.025, respectively), 10-year probability of any major osteoporotic fracture was 18.4 ± 9.6% in women and 9.7 ± 8.6% in men, and the probability of hip fracture - 3.5 ± 3.7% and 1.5 ± 3.9%, respectively. Among all patients, 55% of women and 4% of men had a high risk of subsequent fractures using the FRAX® algorithm.

Conclusion: Low BMD was diagnosed in 68% of women and 55% of men with SSc. The correlations between BMD and age, body mass index, the duration of postmenopause were revealed. Additionally, we found associations with risk factors related to the disease itself: disease duration and glucocorticoid cumulative dose. Reduced BMD was associated with an increased risk of falls and fractures, 55% of women and 4% of men had a high risk of further fractures.

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DISTINCTION BETWEEN TELANGIECTASIA SECONDARY TO CONNECTIVE TISSUE DISEASE AND CUTANEOUS COLLAGENOUS VASCULOPATHY
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Background: Cutaneous collagenous vasculopathy (CCV), a recently described, rare, superficial dermal microangiopathy of unknown etiology, shares clinical and histopathological features in common with cutaneous lupus erythematosus and dermatomyositis. Fewer than 50 cases have been reported in the literature. Concurrence of CCV and connective tissue diseases (CTD) may present a diagnostic quandary.

Objectives: To determine the factors influencing CCV cases at our center were associated with CTD and to identify distinguishing features between CCV and cutaneous manifestations of CTD.

Methods: The laboratory information system at a single academic health care center (2000-2018) was searched to identify cases with a diagnosis of CCV. All pathological material and clinical charts were reviewed. The demographic, clinical and pathological data were documented.

Results: We identified 6 cases of CCV (4 female, 2 male; median age 57 years). Clinically, a telangiectatic eruption was present in all patients, affecting the lower limbs and other sites (N=5) and the abdomen and arms (N=1). All patients had been seen by a dermatologist and 3 by a rheumatologist. A concurrent CTD was present in 2 cases; Sjogren’s syn- drome (N=1) and undifferentiated connective tissue disease (N=1). In all cases, the clinical differential diagnosis included CCV and cutaneous involvement by the CTD. In all 6 cases, histopathological examination revealed a non-inflammaroty vasculopathy, with PAS-positive, diastase resistant, hyaline thickening of ectatic superficial capillary walls, and loss of pericytes. These hallmarks of CCV excluded skin disease attributable to CTD in the two relevant cases.

Conclusion: Concurrence of CCV and CTD, though uncommon, presents a diagnostic challenge. The clinical distribution of the CCV eruption, favouring the lower limbs, and its non-inflammatory character histopathologically distinguish it from cutaneous involvement by a CTD.

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