absence of fibrin deposition in Fg⁻ mice was accompanied by significantly lower synovial inflammation, chondro-synovial adhesion and cartilage damage than in WT mice. Chondro-synovial adhesion correlated with cartilage damage in the WT and led to apparent mechanical stripping of the superficial cartilage, whilst this phenomenon was not observed in the Fg⁻ mice. In vitro, autologous RA synoviocytes adhered to cartilage explants exclusively in the presence of fibrin deposition. Fibrinogen chains were not expressed by primary chondrocytes, indicating passive deposition from synovial fluid or tissue. In human RA cartilage explants, we found colocalization and a significant positive correlation between fibrin and calcific deposits. Fibrinogen caused exacerbated calcification in CPP-treated primary murine chondrocytes and induction of genes involved in chondrocyte calcification (Pocl, Ptit). Cartilage-oligomeric matrix protein (Comp) gene was also highly induced suggesting a pro-catabolic role of fibrinogen.

**Conclusion:** Fibrin deposition is an active trigger of cartilage degeneration in RA via induction of chondro-synovial adhesion (mechanical aspect) and induction of calcification (catabolic aspect). Newer therapeutic approaches may not merely focus on fibrinolysis but protect cartilage from fibrin-induced adhesion or calcification e.g. by fibrin-targeted immunotherapy.

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**AB0093**

**PORPHYROMONAS GINGIVALIS – PERIODONTAL PATHOGEN WITH POTENTIAL ROLL IN RHEUMATOID ARTHRITIS**

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**Background:** In recent literature, a strong association between periodontal disease (PD) and rheumatoid arthritis (RA) has been reported. PD is a common, progressive inflammatory disease, initiated by a bacterial infection that engages the supporting structures of the teeth and leads to tooth loss. A number of common features have been identified between PD and RA. One of the most important associations is the process of ctitrullination, which is caused by the production of PG specific enzyme so called Porphyromonas gingivalis Pglyptid Diminase (PPAD).

**Objectives:** The aim of the study was to show the incidence of PG in RA patients, and to compare it with patients with osteoarthritis (OA) and healthy controls (HC) and to evaluate the possible correlation between the presence of PG in patients with RA and the positivity of anti CCP and anti MCV antibodies in RA patients.

**Methods:** The study included 30 patients with RA which fulfilled RA classification criteria from 2010, 26 patients with osteoarthritis (OA) and 24 healthy controls. All participants were genetically analyzed for the presence of PG by Chelex®100 method and polymerase chain reaction (PCR), by isolating amplified sequences of DNA in a sub gingival biofilm taken from the deep periodontal pockets. The method and polymerase chain reaction (PCR), by isolating amplified sequences of DNA in a sub gingival biofilm taken from the deep periodontal pockets. The presence of anti CCP and anti MCV autoantibodies was detected in the sera of RA patients with ELISA test.

**Results:** The average ages of the patients in the 3 groups were as follows: -51 years for RA, 52 for OA and 58 years for HC. Seventy percent of RA patients were females. Significantly higher levels of PG were found in the periodontal pockets of RA patients. Eighty percent of RA patients (80% or 24 RA patients) were PG positive in comparison with 35% of OA patients and 2% healthy controls. Of the PG-positive RA patients, 83% had positive and 17% had anti-CCP negative test, while of the PG-negative patients, a positive anti-CCP test was present in 33% and a negative anti-CCP test was present in 67%. Accordingly, in PG-positive RA patients positive anti-MCV test was present in 79% and negative anti-MCV test was present in 21%, and in PG-negative RA patients anti-MCV test was positive in 17% and negative in 83% patients.

**Conclusion:** The results of our study indicate that PG is found more frequently in periodontal pockets of patients with rheumatoid arthritis, which implies the important role of oral microbiota in RA pathogenesis, treatment and prevention.

**References:**


**AB0094**

**FUNCTIONAL TREG CELLS MAY BE CONVERTED INTO T EFFECTOR PHENOTYPE ON EXPOSURE TO INFAMMATORY MILIEU IN RHEUMATOID ARTHRITIS (RA) SYNOVIAL FLUID: IN-VITRO STUDY**

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**Background:** The debate on functional versus numerical difference in T regulatory cell population among patients with Rheumatoid arthritis (RA) is not clear. Tregs expressing Inflammatory subset phenotype markers, such as Th1(cxcr3, Tbet) and Th17(ccr6,Rorγt) are reported. (1) Though the reported numbers of synovial fluid tregs are higher in RA, (2) the fate of Tregs on entering the synovial inflammatory milieu from peripheral blood (PB) has not yet been investigated.

**Objectives:** To compare Treg frequencies in PB and synovial fluid between osteoarthrisis (OA) and RA.

To compare cytokine levels in PB and SF between OA and RA.

To study the effect of autologous synovial fluid on RA and OA Treg isolated from peripheral blood.

**Methods:** The Peripheral Blood (PB) and synovial fluid (SF) of RA (n=80) and OA (n=30) patients were analyzed for CD4+T-cell subset frequencies and phenotypes by flow cytometry. Cytokine concentrations in plasma and SF were measured by cytometric bead array. Tregs from 5 RA-PB and 5 OA-PB were isolated and cultured in autologous synovial fluid for 24 hrs. Phenotypic expression of Th1 and Th17 chemokines on the cell surface were analyzed by flow cytometry and expression levels of T-bet, RORγ and FOXP3 in those Treg cells were measured with quantitative real-time PCR (RT-qPCR).

**Results:** The PB and SF frequencies of Th1, Th17 and Tregs are shown in Table 1. The pro-inflammatory cytokines were high in the plasma and SF of RA but the anti-inflammatory cytokines were similar (Fig 1A&B). Treg cells were isolated from RA and OA PB and cultured in autologous SF for 24 hrs. RA Treg showed increased cell surface expression of CXCR3+ and CCRL6+ (Fig 1C) and there was no difference in OA Treg. Gene expression studies showed an increased expression of T-bet, RORγ and decreased expression of Foxp3 in RA Tregs while there was no difference in OA Tregs before and after in-vitro culture (Fig 1D).

**Table 1.**

<table>
<thead>
<tr>
<th>Patient’s groups</th>
<th>RA</th>
<th>OA</th>
<th>HC</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porphyromonas gingivalis positive</td>
<td>24 (80%)</td>
<td>9 (35%)</td>
<td>7 (29%)</td>
<td>RA → OA (p &lt; 0.0001)</td>
</tr>
<tr>
<td>Porphyromonas gingivalis negative</td>
<td>6 (24%)</td>
<td>17 (65%)</td>
<td>17 (71%)</td>
<td>RA → HC (p &lt; 0.0001)</td>
</tr>
</tbody>
</table>

Total | 30 | 26 | 24 |
Table 1. T cell subsets in Rheumatoid Arthritis and Osteoarthritis.

<table>
<thead>
<tr>
<th>CD4 subtype</th>
<th>RA</th>
<th>OA</th>
<th>RA</th>
<th>OA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PB</td>
<td>SF</td>
<td>PB</td>
<td>SF</td>
</tr>
<tr>
<td>N=80</td>
<td>N=30</td>
<td>N=30</td>
<td>N=30</td>
<td></td>
</tr>
<tr>
<td>Th1</td>
<td>26.65 ± 5.59</td>
<td>34.99 ± 1.30</td>
<td>25.97 ± 7.24</td>
<td>26.45 ± 1.87*</td>
</tr>
<tr>
<td>Th2</td>
<td>5.19 ± 1.9</td>
<td>16.36 ± 1.73</td>
<td>5.24 ± 2.15</td>
<td>4.4 ± 0.10*</td>
</tr>
<tr>
<td>Th17</td>
<td>14.05 ± 3.29</td>
<td>21.18 ± 2.04</td>
<td>10.81 ± 2.78*</td>
<td>2.45 ± 0.23*</td>
</tr>
<tr>
<td>Treg</td>
<td>10.68 ± 2.47</td>
<td>12.53 ± 2.10</td>
<td>11.16 ± 9.55</td>
<td>13.04 ± 2.57</td>
</tr>
</tbody>
</table>

*P<0.05

**Conclusion:** Tregs in RA may be converted to Th1 and Th17 phenotype on exposure to inflammatory cytokine in the synovial fluid, thus losing their regulatory functions. Understanding factors influencing stability of Treg cells may help improve future therapeutics.

**References:**


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**Disclosure of Interests:** None declared

**Fig. 1:** Comparison of plasma cytokine levels between RA and OA patients. (A) Comparison of several cytokine levels between for all 3 patients. (B) surface characterization of ovarian cultured peripheral blood Treg cells of RA patients. C: IL-10 and CD69/CD107a (chemokine expressing Treg cells isolated from peripheral blood of patients with RA) and D: IL-10, CD69 and CD107a (chemokine expressing Treg cells isolated from peripheral blood of patients with SA). (C) Immunohistochemistry staining (CD34, CD86, CD11c, CD14 and CD16) for evaluation of Treg cell infiltration in histopathological scores. (D) Percentage of Treg cells in peripheral blood of RA patients. Treg cells were stained by anti-CD3, anti-CD4 and anti-CD25 antibodies followed by immunofluorescence. (E) CD107a chemokine expression was evaluated by immunofluorescence staining on the surface of Treg cells. Treg cells were stained by anti-CD3, anti-CD4 and anti-CD25 antibodies followed by immunofluorescence. (F) CD107a chemokine expression was evaluated by immunofluorescence staining on the surface of Treg cells. Treg cells were stained by anti-CD3, anti-CD4 and anti-CD25 antibodies followed by immunofluorescence.