Methods: We enrolled SSc patients without PH from January 2016 to December 2019 in our institution. SSc patients were diagnosed according to EULAR classification criteria in 2013. ILD was detected by chest CT scans. We assessed severity of ILD with pulmonary function tests (PFT). Abnormal PFT was defined as vital capacity (%VC) or diffusion capacity (DLCO) < 70%. NFC abnormalities were detected with “OptiPiX capillaroscopy Clinic 1.7.x” and the number of capillaries was measured per 1mm in 2nd to 5th fingers of both hand. We defined enlarged and giant capillaries as >30 μm and >50 μm, respectively.

Results: We enrolled 59 SSc patients (64 females, 5 males). Mean age is 65.0 ± 8.0 years. Thirty-one patients (52.5%) were complicated with ILD. Mean capillary counts are 6.6/mm. The number of patients with each NFC abnormalities (enlarged capillaries, giant capillaries, microhemorrhages, ramified, avascular areas) are 42, 32, 48, 38, and 33 cases, respectively. Two cases did not have NFC abnormalities. SSc patients with giant capillaries had fewer ILD complications (p <0.05, odds ratio 0.183 [0.059 – 0.57]). Other NFC abnormalities were not associated with ILD in SSc patients. We inspected %VC of 23 patients and DLCO of 20 patients with ILD. Eleven patients had abnormal PFT (5 patients had abnormal %VC and 9 patients had abnormal DLCO). Most of them had not enlarged capillaries than patient with normal PFT (odds ratio 0.11 [0.016 – 0.81]). Other NFC abnormalities including giant capillaries were not associated with abnormal PFT.

Conclusion: We investigated the relationship between NFC abnormalities and ILD complications in SSc patients. NFC abnormalities are associated with ILD complication and severity of ILD. It was suggested that no giant capillary in SSc patients may predict ILD complication. Moreover, no enlarged capillary may predict the severe ILD.

References:

Table1. each NFC abnormalities in SSc patients

<table>
<thead>
<tr>
<th></th>
<th>With ILD(n=31)</th>
<th>Without ILD(n=28)</th>
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</tr>
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<tbody>
<tr>
<td>enlarged capillaries</td>
<td>19</td>
<td>23</td>
<td>0.08</td>
</tr>
<tr>
<td>giant capillaries</td>
<td>11</td>
<td>21</td>
<td>0.902</td>
</tr>
<tr>
<td>microhemorrhage</td>
<td>25</td>
<td>23</td>
<td>0.86</td>
</tr>
<tr>
<td>ramified</td>
<td>21</td>
<td>17</td>
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</tr>
<tr>
<td>avascular areas</td>
<td>19</td>
<td>14</td>
<td>0.38</td>
</tr>
</tbody>
</table>

Table2. each NFC abnormalities in SSc patients with ILD

Disclosure of Interests: None declared

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AB0594

EFFECTIVENESS OF RITUXIMAB IN CSDMARDS-RESISTANT ACTIVE MIXED CONNECTIVE TISSUE DISEASE

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Background: Objectives: To evaluate rituximab (RTX) effectiveness and safety in treating patients with refractory mixed connective tissue disease (MCTD).

Methods: Open observational study including patients with refractory MCTD (active disease despite treatment with glucocorticoids and csDMARDs) from two third-level hospitals who had been treated with RTX (off-label use) from January 2001 to December 2019.

Results: Thirteen patients (all women) were included, with a mean age of 32 years (SD: 10, range 17-50) and a median time of evolution of the disease of 55 months (SD: 34.3; range 5-98 months). The main indication for initiating treatment with RTX was refractory arthritis (100%), most of the times accompanied by other features of the disease including shrinking lung syndrome (2), fibrosing progressive non-specific interstitial pneumonia (FP-Nsip) (1), recurrent serositis (2), glomerulonephritis (Gmn) (2), lymphadenitis (1) and immune thrombocytopenic purpura (ITP) (1). All patients were treated with RTX at rheumatoid arthritis dosage while the baseline immunosuppressive treatment (methotrexate, azathioprine, mycophenolate, leflunomide or tacrolimus) remained unchanged. Hydroxychloroquine was also associated in 8 of the patients. The follow-up time (median) after starting RTX was 118 months (range, 65-177 months, with a total of 132.6 patient-years of follow-up) and the mean number of cycles of treatment was 4.2 (range, 1-15), with a variable interval (from 6 to 12 months). After the first RTX cycle, a partial or complete response was achieved in 92% of the patients. A significant improvement in the mean DAS28-ESR was observed (initial: 4.56 ± 1.6 / final: 2.21 ± 0.85; p=0.008). In all but one patient, who had previously failed to 2 anti-TNFα

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**EFFECTIVENESS OF TOPICAL SODIUM TIOUSULFATE FOR THE TREATMENT OF CALCINOSIS-ASSOCIATED CUTANEOUS ULCERS IN PATIENTS WITH SYSTEMIC SCLEROSIS**

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**Background:** Treatment of calcinosis associated with systemic sclerosis (SSc) mainly involves the use of systemic therapies, which often have limited efficacy. However, little attention has been paid to local treatment, which is especially useful when associated with skin ulcers.

**Objectives:** To show our experience with topical sodium thiosulfate (TST) for the treatment of calcinosis-associated cutaneous ulcers in patients with SSc.

**Methods:** Descriptive analysis of a case series of patients with SSc and calcinosis-associated skin ulcers treated with TST. Wound management procedure: wounds and perilesional skin cleaning and disinfection is performed and, if needed, additional debridement. TST is compounded at 25%, as a/w emulsion, for extensive calcinosis, or as beeler-base or cold-cream ointment, for limited wounds and perilesional skin. Adverse effect has been detected, except for slight maceration of the wound. Radiological improvement was also observed in 1 case. No TST related improvement in pain, function, quality of life and satisfaction of the patients.

**Results:** Nine patients (7 women) with calcinosis-associated skin ulcers and SSc were included: 2 patients with diffuse SSc (dSSc), 6 with limited SSc (lSSc) and 1 with overlap syndrome. Median age of 60 years (IQR 20), 6 patients had localized wounds and 3 had extensive involvement and/or tumoral calcinosis which had been refractory to systemic treatment with diltiazem, colchicine, zoledronate, rituximab, and/or acenocoumarol and had suffered recurrent superinfections. Follow-up results of more than 3 months are available for 8 patients, who have been on TST a median time of 9 months (IQR 8.25). They have shown clinical improvement (disappearing of many calcinosis foci and partial or complete healing of the ulcers together with an improvement in pain, function, quality of life and satisfaction of the patients). Radiological improvement was also observed in 1 case. No TST related adverse effect has been detected, except for slight maceration of the wound edges due to the ointment preparation, which was resolved by protecting these with zinc oxide cream

**Conclusion:** In our experience, treatment with TST for calcinosis-associated skin ulcers in patients with SSc is an effective, safe and easily implementable therapeutic alternative in clinical practice.

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**Figure 1.** Disease free survival plot of patients with IIM.