patients) and 12 months (6 of 7), and at last available evaluation (6 of 8); all other patients reported stability.

Conclusion: In our experience, patients with DcSSc seem to benefit of early RTX treatment. Improvement may be seen as early as 6 months and seems to reach a plateau at 12 months.

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AB0621 TOLERABILITY AND SAFETY OF ACETYSALICYLIC ACID IN PATIENTS WITH SYSTEMIC SCLEROSIS

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Background: Systemic Sclerosis (SSc) is characterized by an increased incidence of macro- and microvascular complications. Current evidences on efficacy, safety and tolerability of acetylsalicylic acid (ASA) in SSc patients are limited, and the indication to this treatment is based on the experience of each single centre or physician. Esophagus and stomach are the portions of the digestive tract that are more frequently affected by adverse events due to ASA exposure.

Objectives: We evaluated the incidence of adverse events associated with low-dose ASA treatment in a cohort of patients affected by SSc.

Methods: Demographic data and disease features of 302 patients affected by SSc treated with low-dose ASA were collected and patients were followed-up for a median period of 6.9 years (range: 0-20 years). The proportion of patients taking ASA for secondary prevention for cardiovascular disease was also noted. The incidence of discontinuation of the drug, gastrointestinal intolerance, bleeding and death in the observation period was recorded.

Results: Patients had a median age of 54.0 years (19.6-89.4); 91.9% were female, 13.2% were smokers and 44.0% had a BMI ≥ 30 Kg/m². The prevalence of ischemic heart disease, peripheral vascular disease and stroke was of 8.6%, 5.3% and 3.3%, respectively; 48.7% of the patient took ASA in primary cardiovascular prevention. Therapy started after a median disease duration of 4.8 years (range: 0.0- 30.1 years) since the first non-Raynaud symptom and 56.6% of patients had an early disease (less than three years of disease duration). During the observation period, 30 patients (14.3 per 1000 person-years) discontinued ASA after an average period of assumption of 4.6 years (range: 0.3-18.0 years). The main adverse events were heartburn, dyspepsia and hematochezia, recorded in 18 patients (8.6 per 1000 person-years). Eight of them (3.8 per 1000 person-years) had evidence of digestive tract bleeding. Five patients (2.4 per 1000 person-years) discontinued ASA due to recurrent epistaxis. Twenty-eight patients (13.4 per 1000 person-years) died in the follow-up period, 16 of these (7.6 per 1000 person-years) because of SSc-related causes. None of them had evidence of major bleeding. We used Kaplan-Meier analysis to evaluate the incidence of ASA discontinuation. The history of digital ulcers (Log rank test X^2 4.7, $p=0.037$) and male sex (Log rank test X^2 4.3, $p=0.03$) were associated with a higher cumulative ASA discontinuation rate due to gastrointestinal intolerance.

Conclusion: In our cohort of SSc patients, ASA resulted safe and well tolerated in most cases, despite the risk of gastroesophageal abnormalities due to disease. Although this comforting results, taking in account the lack of controlled-randomized trials about efficacy and safety, the choice to start antiplatelet therapy with ASA should be mandatorily preceded by a careful evaluation of risks and benefits. Furthermore, an attentive monitoring for possible adverse effects is needed during ASA treatment. Patients with digital ulcers and male sex could present less drug tolerability.

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AB0622 ASSOCIATIONS WITH DIGITAL PITTING IN SYSTEMIC SCLEROSIS: A RETROSPECTIVE ANALYSIS.

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Background: Digital pitting, the loss of tissue at the fingertip, is a cardinal feature of systemic sclerosis (SSc), contributing 3 of the 9 required points to fulfil the 2013 ACR/EULAR classification criteria. However, research into digital pitting has been scarce, despite it being painful and impacting on hand function.

Objectives: To identify factors associated with digital pitting in patients with SSc. **Methods:** This was a retrospective analysis of data from patients with SSc attending a tertiary referral centre. Patients were subdivided into those with and without digital pitting, as recorded at their last documented attendance. The following variables were analysed: age, gender, age at Raynaud's onset, age at SSc onset, limited/ diffuse cutaneous subtype, history of intravenous (IV) vasodilators, amputations, debridements and autoantibody status (anti-RNA polymerase, anti-Scl70, anti-centromere and anti-RNP).

Results: Data were available from 713 patients with SSc. Digital pitting was present in approximately half of these patients (n=362, 51%). Table 1 summarises their characteristics.

Table 1. Descriptive statistics of patients with and without digital pitting

	Digital Pitting (n=362)	No Digital Pitting (n=351)
Age, mean (SD)	67.1 (14.5)	66.5 (13.6)
Females, n (%)	287 (79.3)	301 (85.8)
Age at Raynaud's onset/ Age at SSc onset, median (IQR)	39.3 (25.2, 49.3)/ 41.4 (26.2, 52.5)	47.5 (35.3, 57.3)/ 52.5 (41.9, 60.4)
Limited/ Diffuse subtype, n (%)	276/85 (76.5/ 23.6)	257/93 (73.6/ 26.6)
History of IV vasodilators, n (%)	167 (46.4)	52 (14.9)
History of amputations, n (%)	52 (14.4)	5 (1.4)
Debridements, n (%)	72 (20.2)	18 (5.1)
Autoantibody status, n (%):	13 (6.2) ¹ / 61 (17.1) ³ / 152 (42.6) ⁵	34 (14.0) ² / 41 (12.0) ⁴ / 22 (6.5) ⁶
Anti-RNA polymerase/ Anti-Scl70/ Anti-centromere/ Anti-RNP	15 (4.3) ⁷	120 (35.4) ⁸ / 22 (6.5) ⁹

Denominator populations ¹210, ²246, ³357, ⁴345, ⁵357, ⁶341, ⁷352, ⁸341

From the univariable analysis (Table 2), gender (female, $p=0.02$), age at Raynaud's onset ($p<0.001$), age at SSc onset ($p<0.001$), IV vasodilators ($p<0.001$), amputations ($p<0.001$), debridements ($p<0.001$), anti-RNA polymerase ($p=0.01$), anti-Scl70 ($p=0.05$) and anti-centromere ($p=0.05$) were found to be significantly associated (anti-RNA polymerase negatively ($p=0.20$)) with digital pitting ($p\leq 0.05$). Further analysis adjusting the p value for multiple testing (Bonferroni adjustment, $p\leq 0.0036$) found age at Raynaud's onset, age at SSc onset, history of IV vasodilators, amputations and debridements to be significantly associated with digital pitting.

Table 2. Univariable logistic regression

	Odds Ratio	95% Confidence Interval	P value ¹	Number of patients in each analysis
Age	1.000	0.998 to 1.003	0.62	713
Female	1.116	1.015 to 1.231	0.02	713
Age at Raynaud's onset	1.008	1.007 to 1.010	<0.001	713
Age at SSc onset	1.004	1.003 to 1.005	<0.001	713
Limited/ Diffuse subtype	1.039/ 1.041	1.049 to 1.127/ 1.046 to 1.139	0.39/ 0.35	710/ 711
History of IV vasodilators	1.448	1.336 to 1.553	<0.001	710
History of amputations	1.553	1.363 to 1.768	<0.001	713
Debridements	1.405	1.259 to 1.568	<0.001	707
Autoantibody status:	1.223/ 1.111/ 1.052 to 1.419/ 1.000 to 0.01/ 0.05/	456/ 702/ 698/		
Anti-RNA polymerase/ Anti-Scl70/ Anti-centromere/ Anti-RNP	1.081/ 1.114	1.234/ 1.002 to 1.162/ 1.310 to 1.786	0.05/ 0.20	693

¹ $p\leq 0.05$

Conclusion: The results from this exploratory study in a large cohort of SSC patients provide valuable insights into factors associated with digital pitting. Patients with digital pitting often have an earlier onset of Raynauds and of SSC and significantly more debridements/amputations, suggesting that digital pitting is associated with vascular disease severity. Our findings indicate the need for further research investigating pathophysiology of digital pitting, to inform development of preventative treatment strategies.

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AB0623

RATE AND PREDICTIVE FACTORS ASSOCIATED WITH SUSTAINED REMISSION IN IDIOPATHIC INFLAMMATORY MYOSITIS

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Background: Idiopathic inflammatory myositis (IIM) is a group of heterogeneous connective tissue diseases, characterised by chronic muscle inflammation, myositis-specific or myositis-associated autoantibodies and different extra-muscular features. Achieving low disease activity or remission in patients with IIM has proven to be difficult due to the wide clinical spectrum of the different IIM types.

Objectives: To retrospectively assess any predictive factors for sustained remission in IIM patients

Methods: We retrospectively analyzed data taken from medical charts, which included age at disease onset, gender, laboratory data as well as clinical features present at onset, organ involvement and treatment history. A total of 151 adult patients with IIM followed-up for > 1 year were retrospectively enrolled. Remission was defined as no clinical and laboratory evidence of disease activity persistent for more than 6 months during follow-up, while undergoing myositis therapy or under no medication. The remission of cutaneous involvement was defined as no current activity of skin rash, absence of Gottron's papules as well as heliotrope rash and erythema, whereas the remission of pulmonary involvement was considered as no requirement for intensification of immunosuppressive therapy during follow-up. Likewise, absence of muscle weakness or hyposthenia was taken into account for evaluating muscle involvement. Moreover, the clinical features were accompanied by normalization of myogenic enzymes such as creatine kinase (CK) and lactate dehydrogenase levels.

Results: Among all 151 patients, 89 (58.9%) patients achieved sustained remission. By univariate analysis, overlap myositis (7.9% vs 27.4%; $p=0.003$; OR:0.22), cancer-associated myositis (CAM) (7.8% vs 19.35%; $p=0.046$; OR:0.3), as well as the presence of anti Ku (3.37% vs 12.9%; $p=0.05$; OR:0.23) and anti TIF-1 gamma (1.1% vs 8%; $p=0.043$; OR:0.13) antibodies and polyarthritis (11.2% vs 24.19%; $p=0.045$; OR: 0.397) at onset were significantly associated with active IIM, not achieving remission.

Out of 89 patients in remission, 79 (88.8%) achieved long-term sustained remission, lasting at least 2 years, whereas 10 patients (11.2%) showed relapse. Most of relapsed patients showed a relapse/remitting disease, with no evident trigger for the relapse. We divided our cohort of 89 patients in remission in 2 subsets: 83 patients in remission undergoing therapy (93.3%) and 6 patients in drug-free remission (6.7%). No significant differences were found between two groups, except for younger age at onset ($p=0.0002$) found in patients achieving drug-free remission.

Conclusion: Sustained remission occurs in about one half of patients with IIM. The presence of anti Ku and anti TIF-1 gamma antibodies as well as polyarthritis at onset lowers the chance of achieving sustained remission. Younger age at diagnosis has proved to predict drug-free long-lasting remission.

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AB0624

PREDICTIVE PARAMETERS FOR DEVELOPMENT OF INTERSTITIAL LUNG DISEASE IN IDIOPATHIC INFLAMMATORY MYOSITIS

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Background: Idiopathic Inflammatory Myositis (IIM) is a group of heterogeneous connective tissue diseases, primarily characterized by chronic muscle inflammation as well as myositis-specific or myositis-associated autoantibodies and a spectrum of different extra-muscular features.

The most frequent organ involvement in IIM is Interstitial Lung Disease (ILD), occurring in 5-80% of different IIMs cases and considered the hallmark of morbidity and mortality in patients with IIMs.

Objectives: To retrospectively assess the predictive factors for development of ILD in IIM patients

Methods: We retrospectively analyzed the prevalence of ILD in a single-center cohort of 165 IIM patients. Patient data was collected from clinical charts. ILD was diagnosed by chest X-ray scan and chest CT scan. All chest CT and chest X-ray scans available and performed at our hospital were consequently re-evaluated by our expert pneumologist for uniform evaluation.

Results: Myositis-related ILD (M-ILD) was found in 52 IIM patients (31.5%): 46.15% was affected by anti-synthetase syndrome (ARS), 21.15% by polymyositis (PM), 19.23% by dermatomyositis (DM) and 13.46% by overlap myositis. The pulmonary involvement was characterized by Non-specific interstitial pneumonia (NSIP) (30.6%), Unusual Interstitial Pneumonia (UIP) (38.77%), Bronchiolitis Obliterans with Organizing Pneumonia (BOOP) (20.4%), overlap NSIP/BOOP (4.1%) and Undetermined/Unspecific pattern (6.12%). Eighty four percent of M-ILD consisted of non-smokers and 69.23% presented with dyspnea at onset.

ILD was diagnosed in 90.38% of patients within the first year of IIM diagnosis (early onset ILD) and was associated with dyspnea and/or cough in 70.2% and 17% respectively. On the other hand, late onset ILD presented mostly with dyspnea and/or cough in 60% of cases and was significantly associated with anti-Ku antibodies.

At onset ILD was significantly associated with: ARS ($p<0.0001$; OR:12.98), anti-Jo-1 ($p<0.0001$; OR:6.1), anti-Ro ($p=0.038$; OR:2.2), mechanic's hands ($p<0.0001$; OR:10.41), arthritis ($p=0.01$; OR:2.58), polyarthritis ($p=0.001$; OR:4.578), dyspnea ($p<0.0001$; OR:9.66), and high levels of CPK ($p=0.0001$) and GOT ($p=0.0146$). By contrast, the following features: DM ($p=0.012$; OR:0.36), facial rash ($p=0.003$; OR:0.31), anti-NXP-2 ($p=0.019$; OR<0.0001), anti-PL-12 ($p=0.03$; OR<0.0001) and myositis ($p<0.0001$; OR:0.173) present at onset were less frequently associated with M-ILD.

At multivariate analysis M-ILD was predicted by anti-Ro ($p=0.0448$), polyarthritis ($p=0.0093$) and dyspnea ($p=0.0001$) at onset. On the other hand, patients presenting myositis ($p=0.0383$) and facial rash ($p=0.0398$) at onset were less likely to develop M-ILD.

Conclusion: ILD occurs in about one third of patients with IIM, mostly affected by ARS. The presence of anti-Ro antibodies as well as polyarthritis and dyspnea at onset predict the development of ILD.

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AB0625

IS PULMONARY ARTERIAL HYPERTENSION, ASSOCIATED WITH SYSTEMIC SCLEROSIS REVERSIBLE?

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Background: Systemic sclerosis (SSc) is one of the frequent causes of the pulmonary arterial hypertension (PAH) which found in 6-15% patient with SSc. Patients with PAH, associated with SSc have a poorer prognosis than other forms of PAH. 6 World Symposium of PH lowered diagnostic cut-off to 21 mm Hg in hope of improved survival. PAH reversibility is described in congenital heart defects, HIV and some tumors

Objectives: The aim of the study to detect reversibility of PAH associated with SSc.

Methods: Hemodynamics (mean pulmonary artery pressure (MPAP), pulmonary artery wedge pressure (PAWP), cardiac output (CO) and pulmonary vascular resistance (PVR)), functional class (NYHA), 6-minute walk distance (6MWD), biomarkers and DLCO were assessed. Patients with pulmonary fibrosis and left heart diseases were excluded.

Results: The study includes 56 patients receiving start-up monotherapy with 1st generation PAH-specific drugs: bosentan (25 patients) and sildenafil (31 patients). The median age of the patients was 51.5 (37; 58) years. At the time of diagnosis, the MPAP in the sildenafil group was 49 (30; 50) mm Hg, bosentan - 50 (42; 56) mm Hg, differences not significant ($p = 0.11$). During observation against the background of sildenafil intake,