Conclusion: Our study revealed relationship of anti-Jo-1 and anti-Ro-52 but not anti-MDA-5 in ILD-inflammatory myopathies. Even though new autoantibodies panel give opportunity to a closer look for inflammatory myopathies, larger series of patients should be evaluated to determine the association of specific antibodies in the differential diagnosis and prediction of outcome of IIM. MSA positivity in non-IIM diagnosed patients should be monitored to determine whether this positivity is related to a future disease development.

Table 1: Frequency of MSAs and IMAs in idiopathic inflammatory myositis

<table>
<thead>
<tr>
<th>ZDM/DM (n=28 patients)</th>
<th>PM/ASS (n=25 patients)</th>
<th>All (n=53 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Myositis-specific autoantibodies, n(%)</strong></td>
<td><strong>Myositis-specific autoantibodies, n(%)</strong></td>
<td><strong>Myositis-specific autoantibodies, n(%)</strong></td>
</tr>
<tr>
<td>Anti-Jo-1</td>
<td>1 (3.6%)</td>
<td>9 (25.7%)</td>
</tr>
<tr>
<td>Anti-Jo-1/ME</td>
<td>5 (11.1%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-SSA/Ro</td>
<td>2 (7.1%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-SSB/Ro</td>
<td>4 (15.4%)</td>
<td>2 (8.0%)</td>
</tr>
<tr>
<td>Anti-52</td>
<td>4 (15.4%)</td>
<td>2 (8.0%)</td>
</tr>
<tr>
<td>Anti-52A</td>
<td>2 (7.1%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-M2-M2a</td>
<td>2 (7.1%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-M2-M2b</td>
<td>2 (7.1%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-RNP</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anti-PM1/12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anti-Sm</td>
<td>1 (3.4%)</td>
<td>3 (12.0%)</td>
</tr>
<tr>
<td>Anti-Cent</td>
<td>1 (3.4%)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Myositis-associated autoantibodies, n(%)</strong></td>
<td><strong>Myositis-associated autoantibodies, n(%)</strong></td>
<td><strong>Myositis-associated autoantibodies, n(%)</strong></td>
</tr>
<tr>
<td>Anti-PL7</td>
<td>4 (15.4%)</td>
<td>8 (32.1%)</td>
</tr>
<tr>
<td>Anti-PM-Scl 100</td>
<td>1 (3.4%)</td>
<td>1 (4.0%)</td>
</tr>
<tr>
<td>Anti-PM-Scl 70</td>
<td>3 (10.7%)</td>
<td>4 (16.0%)</td>
</tr>
<tr>
<td>Anti-Ron</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Disclosure of Interests: Gözde Kübra Yardımçı: None declared, Enes Erul: None declared, Emre Bilgin: None declared, Bayram Farısoğulları: None declared, Levent Kilic: None declared, Zeynep Sarı: None declared, Umut Kalyoncu: Consultant of: Abbvie, Amgen, Lilly, Viatris, Ali Akdoğan: None declared, Burcin Sener: None declared, Şu Leş Bilgen: None declared, Omer Karadağ: None declared

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AB0629 VASCULAR MANIFESTATIONS OF SYSTEMIC SCLEROSIS IN SIMILAR PATHOGENESIS, DIFFERENT IN FREQUENCY

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Background: Pulmonary arterial hypertension (PAH) is one of the main manifestations of vascular involvement in systemic sclerosis (SSc). The association of PAH with Raynaud’s phenomenon (RP) and digital ischemic disorders is assumed.

Objectives: The aim of the study to detect of the possible relationship of pathogenetically similar processes and the predictor role in the early diagnosis of PAH and digital ischemic disorders by the nailfold videocapillaroscopy (NVC).

Methods: 111 patients with SSc (51 patients with PAH (SSc-PAH) and 60 patients without PAH) include in this study. In all patients, the diagnosis of SSc was validated according to the 2013 ACR-EULAR criteria. PAH was diagnosed by right heart catheterization. NVC was performed in all recruited subjects. Capillary quantitative parameters (loops length and width, capillary density, neoangiogenesis) were evaluated and a semi-quantitative scoring was used (specific patterns - early, active and late) to define microvascular alterations.

Results: RP was detected in 100% of cases in both groups. In the analysis of capillaroscopic patterns in both groups, the early and late scleroderma types of changes prevailed, but no significant differences were noted. Typical scleroderma patterns were found in 51 patients (100%) with SSc-PAH. In 3 patients with SSc without PAH, the abnormalities were regarded as non-specific. The NVC pattern was detected to be early in 8 patients with SSc-PAH and in 11 with SSc without PAH. The NVC pattern was found to be active in 16 patients with SSc-PAH and in 18 with SSc without PAH. The NVC pattern was found to be late in 27 patients with SSc-PAH and in 28 with SSc without PAH. In addition to RP, the development of digital ulcers was noted with equal frequency in history (25 patients with SSc-PAH and 32 with SSc without PAH). Also, the time to their appearance from the first symptom of SSc was the same (56 (16-84) months and 44 (23-72) months, respectively). Severe forms of digital ischemic disorders were observed rarely and with the same frequency in the studied groups. Ischemia in 2 patients with SSc-PAH and in 5 patients with SSc without PAH; gangrene in 2 patients only in the SSc group without PAH, amputation in 1 of each group.

Conclusion: In the course of the study, it was not possible to identify differences between the NVC patterns, the frequency and severity of digital ischemic disorders in the compared groups. That fact does not allow using the NVC as an early diagnosis of PAH in SSc. However, the NVC can help predict the development of digital ischemic disorders.

References: No

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6437

AB0630 IMBALANCE BETWEEN TH17 AND REGULATORY T CELLS IN PATIENTS WITH PM/DM COMBINED WITH EBV/CVM VIREAEMIA

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Background: Dermatomyositis and polymyositis (DM/PM) are associated with muscle weakness and inflammatory infiltration within the skeletal muscle. The numerical and functional defects of immune cells, due to long-term uses of glucocorticoids and disease-modifying anti-rheumatic drugs (DMARDs) together with immune disturbances associated with disease itself, lead to high risks in opportunistic infections, such as Epstein-Barr virus (EBV) and cytomegalovirus (CMV). We want to observe changes of peripheral lymphoeytessubsets in PM/DM patients with EBV and/or CMV infection, especially whether there is imbalance between Th17 and Treg cells.

Objectives: To investigate the characteristics of peripheral lymphocyte subsets in PM/DM with EBV and/or CMV infection, especially the Th17 and Treg cell counts.

Methods: From February 2016 to November 2019, PM/DM patients with EBV and/or CMV viremia (infection group, n=34) and without infection (non-infection group, n=31) as well as healthy adult controls (n=20) were enrolled in our study. Absolute numbers of total T, total B, NK, CD4 + T, CD8 + T cells, and CD4 + T subsets (Th1, Th2, Th17 and Treg cells) in peripheral blood by flow cytometry were compared with standard absolute counting beads.

Results: (1) Compared with PM/DM patients without infection, 34 PM/DM patients with EBV and/or CMV infection, including 12 patients with EBV, 20 patients with CMV, 2 patients combined EBV and CMV, the absolute number of total T lymph cells (P=0.019), total B lymph cells (P=0.037), Th1 cells (P=0.033), CD4 + T cells (P=0.000), Th1 cells (P=0.014), Th2 cells (P=0.003), Th17 cells (P=0.003), Treg cells (P=0.004) lower than its of (P=0.003) patients without infection, the absolute number of CD8 + T cells (P=0.427) has no obvious difference between them.

(2) And its the absolute number of total T lymph cells (P=0.000), total B lymph cells (P=0.003), NK cells (P=0.000), CD4 + T cells (P=0.031), CD8 + T cells (P=0.006), Th1 cells (P=0.000), Th2 cells (P=0.001), Th17 cells (P=0.000) and Treg cells (P=0.000) significantly lower than healthy control.

(3) Compared with the healthy control, the absolute number of total T lymph cells (P=0.000), NK cells (P=0.000), CD4 + T cells (P=0.031), CD8 + T cells (P=0.000), Th1 cells (P=0.002), Th2 cells (P=0.031), and Treg cells (P=0.000) in PM/DM without infection evidently lower, but there is no significant difference in absolute number of total B lymph cells (P=0.19) and Th17 cells (P=0.171).

Conclusion: We show that the absolute number of peripheral blood lymphocytes and CD4+T subsets in patients with PM/DM with EBV and/or CMV viremia is further reduced. In addition to Treg cells, a decrease in Th17 cells may also be an important feature of EBV and CMV infection in PM/DM. These cell reductions may be the cause and risk indicator of viral infections.

References:
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THE CLINICAL CHARACTERISTICS OF SYSTEMIC SCLEROSIS WITH LUNG CANCER: DATA FROM SINGLE CENTER IN CHINA

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Background: Malignant neoplasms is the second most common non-SSc associated cause of death in SSc patients, only second to infection. Among all the neoplasms, lung cancers are the most common, which is in the urgent need of attention from clinicians.

Objectives: To analyze the clinical features of patients of SSc with lung cancer.

Methods: Medical records of inpatients admitted in Peking Union Medical College Hospital from March 1992 to December 2018, were collected and analyzed, including the clinical manifestation, laboratory data, radiological images, pathology. SSc patients without lung cancer during the same period, matched by age and gender, were selected as the controls.

Results: Nineteen SSc patients with complete medical records were identified, with 17 (89.5%) females and 2 (10.5%) males. The mean age of SSc onset was 37.8±12.0 years old and of lung cancer diagnosis was (54.4±10.2) years old. One (5.3%) had a smoking history. Eight patients tested EGFR gene mutation or ALK gene rearrangement, and only 2 were positive.

Conclusion: It is not uncommon that SSc could be concomitant with lung cancer, especially for those with long disease duration and family history of malignancy. Due to the subtle onset of lung cancer, clinicians should pay attention to it during clinical practice.

References:

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20. Spondyloarthritis - treatment

AB0632

EFFECTIVENESS OF ETANERCEPT BIOSIMILARS IN REACTIVE ARTHRITIS: RETROSPECTIVE CASE CONTROL

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Background: There is a paucity of evidence based therapies for reactive arthri-

tis(ReA). Data is limited for anti-TNF drugs usage [Table 1], with even less data on biosimilars.

Table 1. Anti-TNF use in reactive arthritis

<table>
<thead>
<tr>
<th>Place (year)</th>
<th>Anti-TNF</th>
<th>N</th>
<th>Outcomes</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania, USA (2005)</td>
<td>Etanercept</td>
<td>16</td>
<td>10 completed trial: 9 responders</td>
<td>Synovial histology improvement but not normalized</td>
</tr>
<tr>
<td>Strasbourg, France (2011)</td>
<td>Etanercept (4), Adalimumab (1)</td>
<td>15</td>
<td>5 had DFR</td>
<td>Relapses responded to re-initiation</td>
</tr>
<tr>
<td>Besançon, France (2016)</td>
<td>Etanercept (3), Adalimumab (3)</td>
<td>15</td>
<td>5 had DFR</td>
<td>9 developed chronic</td>
</tr>
<tr>
<td>Delhi, India (2019)</td>
<td>Infliximab (10), Etanercept (1)</td>
<td>15</td>
<td>At median of 3.5 months: 4 had remission, 3 relapse, 1 adverse reaction</td>
<td>Biologicals were not given regularly</td>
</tr>
</tbody>
</table>

Current study | Etanercept biosimilar | 10 | At median 7 months: All patients had drug free remission |

DFR: drug free remission

Objectives: To find out the outcomes of etanercept biosimilars (ETN-b) use in ReA.

Methods: A retrospective review of patients meeting the Braun criteria9 for probable ReA helped identify patients on ETN-b. Patients with less than 1 year follow-up and those who had received less than 5 doses of ETN were excluded. Biological naïve patients who had completed at least 1 year follow-up were included as controls. Baseline and current status was compared between these two groups.

Results: Of 94 identified ReA patients, 11(11.7%) had received ETN-b and 10 met the case definition. Each had one received one of two ETN-b, 30 were available as controls. All cases had been documented as refractory ReA. Amongst cases, 7 patients had resolution of ReA; 2 had relapsing courses and 1 persistent arthritis. Four were in remission off all drugs. Controls has similar proportions [Table 2]. There were no infections or adverse effects recorded during follow-up.