The presence of a US fibrotic TS had an AUC of 0.561 (95% CI 0.480-0.643); with Se= 0.139 (0.094-0.199) and spe=0.983 (0.909-0.997). The US-SSc pattern had a AUC of 0.641 (0.563-0.695), with Se=0.440 (0.367-0.516) and spe=0.845 (0.731-0.916). When used as a diagnostic tool, the origin 2013 classification criteria had an AUC of 0.982 (0.969-0.996) with Se= 0.946 (0.900-0.971) and spe=0.931 (0.836-0.973). Including UAO and fibrotic TS in this classification had few impact (AUC of 0.979 (0.962-0.996) with Se=0.940 (0.893-0.967) and and spe=0.931 (0.836-0.973)) but allows the substitution of some items (such as capillaroscopy) by US parameters with similar performances for diagnosis.

Conclusion: The use of hand US parameters may help to refine the diagnostic strategy of SSc and their inclusion in addition with the items of the ACR/EULAR classification could be discussed.

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CHARACTERIZATION OF ANTI-MYOSITIS ANTIBODY RELATED MYOPATHIES. DESCRIPTIVE STUDY IN A MULTICENTRIC COHORT.

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Background: Idiopathic inflammatory myopathies (IMM) are a group of rare diseases consisting on immune-mediated muscle damage. About 40 to 60% show specific-myositis antibodies; additionally, 20-40% can show myositis-related (non-specific) antibodies. The profile of antibodies can help to divide patients into subgroups with more homogeneous clinical characteristics and prognosis.

Objectives: This study characterizes patients with IMM with specific or related anti-myositis antibodies, in five hospitals in the Alicante health area.

Methods: This is an observational study, carried out in five hospitals with a reference population of 1,083,463 people. Patients with positive anti-myositis antibodies between October 2015 and May 2018 were selected from the database of the Clinical Laboratory of the University Hospital of Alicante. We considered the following antibodies: anti-myositis specific antibodies (anti-TIF1γ, anti-MDA5, anti-MI-2, anti-PmScl70, anti-PmSc100, anti-NXP2, anti-SRP), anti-synthetase antibodies (anti-PL7, anti-PL12, anti-Jo1, anti-OJ), myositis-related antibodies (anti-Ro52, anti-Ku). Clinical records were examined, identifying those patients with a diagnosis of IMM according to their clinician, rheumatologist, epidemiologist, and clinical data were obtained.

Results: 291 patients with positive anti-myositis antibodies were identified. Among them, 40 patients had a diagnosis of IMM. Median age was 59.5 (IQR 41.5, 70) years and 68% were women. Within the subgroups, the most frequent diagnosis were dermatomyositis (n=22; 55%) and polymyositis (n=9; 22%). The most common antibody detected was anti-TIFγ among specific antibodies, and anti-Jo-1 among the anti-synthetase antibodies. The most common extramuscular feature was skin involvement. The presence of interstitial lung disease was reported in about one third of patients, being UIP the most common pattern. Regarding treatment, the use of steroids was generalized; methotrexate was the most used immunomupresor agent. Eight patients had a cancer related myopathy.

Conclusion: This register allows us to characterise patients with inflammatory myositis in our area. It is important to make multicentric and prospective registers in infrequent diseases such as IMM in order to have more detailed and representative information about clinical and socio-demographic characteristic as well as prognostic data from these patients.

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