REFERENCES:

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Disclosure of Interests: Mustafa Erdogan: None declared, Burcak Klickirkan Avci: None declared, Canus Ebrun: None declared, Yagmur Ersoy: None declared, Zeki Onen: None declared, Gul Ongen: None declared, Zeki Ongen: None declared, Gulen Hatemi Zeki Ongen: None declared, Vedat Hamuryudan Avci: None declared, Cansu Ebren: None declared, Mustafa Erdogan: None declared, Burcak Kilickiran

Background: Systemic sclerosis (SSc) is a systemic autoimmune disease characterized by progressive cutaneous and internal organ fibrosis. Orofacial manifestations are disabling and treatment options are limited. Fat tissue grafting (FTG) can be used for treating facial manifestations of the fibrosis.

Objectives: In this study, we aimed to assess the safety and efficacy of FTG of our cohort of patients with SSc.

Methods: We enrolled 20 SSc (18W, 2M) patients, from 2016 to 2019, suffering from facial sclerosis and restricted mouth opening capacity. FTG was carried out in accord with modified Coleman’s procedure (1): fat tissue was taken from periumbilical or trochanteric areas and was injected in 8 different points around the mouth. No side effects or adverse reactions have been documented. Evaluations included mouth opening capacity by measuring interincisal distance, oral functionality (MHISS scale) and patient global satisfaction (by Global Health scale).

Results: A 11 mm (8 - 18mm range) median increase of interincisal distance was reported at month 6 and in 80% of patients at month 12, too (p<0.05). Significant improvement in MHISS scale was also observed (p<0.003). The patient satisfaction questionnaire showed 95% positive results and 80% of the patient replied affirmatively to the question about the repetition of FTG but only 2 patients required new FTG after 12 months.

Conclusion: Our results showed that FTG improved mouth opening capacity and that aesthetic and functional results were satisfying to about 90% of the patients; long-term effects of this type of treatment are currently unknown. However, our and literature data at 12 months follow-up seems to confirm the benefits in long term, despite the filling effect is over.

This study – that’s one of the largest case series described right now (2) - supported the possible therapeutic role of autologous FTG in improving facial scleroderma both in aesthetic and in functional aspects.

References:

Disclosure of Interests: None declared DOI: 10.1136/annrheumdis-2020-eular.1527

Table 1. Clinical Features of Patients

<table>
<thead>
<tr>
<th>Feature</th>
<th>All Patients (n=20)</th>
<th>ESC/ERS (n=10)</th>
<th>DETECT (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (IQR)</td>
<td>60 (55-65)</td>
<td>55 (55-65)</td>
<td>65 (60-70)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>12 (60%)</td>
<td>6 (60%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Gender</td>
<td>10 (50%)</td>
<td>5 (50%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>Symptomatic duration, year (IQR)</td>
<td>3 (2-5)</td>
<td>3 (2-5)</td>
<td>3 (2-5)</td>
</tr>
<tr>
<td>Maximum size (mm)</td>
<td>4 (3-5)</td>
<td>4 (3-5)</td>
<td>4 (3-5)</td>
</tr>
<tr>
<td>Minimum size (mm)</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
</tr>
<tr>
<td>Duration of symptoms, year (IQR)</td>
<td>3 (2-5)</td>
<td>3 (2-5)</td>
<td>3 (2-5)</td>
</tr>
</tbody>
</table>

Figure. Number of patients who required RHC according to the algorithms

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Background: anti-NXP2 antibodies is considered a serological marker of dermatomyositis (DM), with calcinosis, severe myositis and, in some series, cancer. Historically, these associations have been detected with immunoprecipitation (IP), but in the last few years commercial line blot (LB) assay have been released. Objectives: to analyze the clinical features associated to anti-NXP2 antibodies, including the onset of concomitant cancers, both with LB and homemade IP.

Methods: clinical and serological data from medical charts of 213 patients with clinical and serological data from medical charts of 213 patients with dermatomyositis were collected. Anti-NXP2 antibodies were examined by line blot assay (LB), but in the last few years commercial line blot (LB) assay have been released. Anti-NXP2 antibodies were detected in serum by IP (immunoprecipitation), but in the last few years commercial line blot (LB) assay have been released. Methods: I: clinical and serological data from medical charts of 213 patients with clinical and serological data from medical charts of 213 patients with dermatomyositis were collected. Anti-NXP2 antibodies were examined by line blot assay (LB) and in the last few years commercial line blot (LB) assay have been released. Anti-NXP2 antibodies were detected in serum by IP (immunoprecipitation), but in the last few years commercial line blot (LB) assay have been released. Anti-NXP2 antibodies were detected in serum by IP (immunoprecipitation), but in the last few years commercial line blot (LB) assay have been released.

Results: clinical diagnosis of anti-NXP2 antibodies was confirmed by protein and RNA IP, as previously described (1)

Results: clinical diagnosis of anti-NXP2 was positive with LB were 42 DM, 11 PM, inclusion body myositis (IBM) 4, necrotizing myositis and overlap (OM) 1 each. Anti-NXP2+ showed a lower age at onset (p<0.0001) more frequent myositis (75%, vs 70%, vs 68% and IB; 35%, vs 25%, vs 29% and IBM), retracted fingers, nailfold capillary abnormalities, myositis (93% vs 79%, OR=3.3), concomitant presence of another MSA (12.7% vs 2%, OR=6.41) and lower rate of features associated with OM or anti-synthetase syndrome. Serum from 49 NXP2+ was available and IP analysis

References:

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