between AS pts and HC (10.5; 8.3-18.0 pmol/l vs 11.9; 8.2-18.3 pmol/l; p<0.05). The same levels of IL-6 and IL-8 were detected in AS with IBD and AS without signs of IBD (p>0.05). In AS pts, serum IL-6 concentration was positively correlated with ASDAS ESR (r = 0.3) and CRP (r = 0.3) and CRP (r = 0.3) and CRP (r = 0.3) and CRP (r = 0.3). IL-8 was negatively associated with presence of fecal calprotectin (r = -0.3; p < 0.05).

**Conclusion:** Elevated serum concentration of IL-6 in AS is associated with clinical and laboratory markers of high inflammatory activity of the disease. The levels of IL-8 in the sera of AS patients were negatively correlated with the concentration of fecal calprotectin. Data on the relationship of IL-8 with the activity of the pathological process in AS require further study.

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**FR0565**

PREVALENCE AND SIGNIFICANCE OF ANTIBODIES AGAINST CITRULLINATED ALPHA-ENOLASE (ANTI-CEP1) IN CONNECTIVE TISSUE DISEASES.

A. Alunno1, F. Carubbi2, O. Bistoni1, M. Antonacci1, E. Bartolini Bocci1, R. Giacomelli2, R. Gerli1,3, Rheumatology Unit, University of Perugia, Perugia, Italy; 2Rheumatology Unit, University of Udine, Udine, Italy

**Background:** Anti-cyclic citrullinated peptide (anti-CCP) auto-antibodies represent the current gold standard for the diagnosis of rheumatoid arthritis (RA). However, growing evidence suggests that a variety of other citrullinated self-proteins may act as autoantigens and lead to the production of autoantibodies (1).

Furthermore, autoantibodies believed to be RA-specific have been detected also in patients with connective tissue diseases (CTDs). We recently demonstrated that antibodies against citrullinated alpha-enolase (anti-CEP1) are a biomarker of erosive disease and RA-associated interstitial lung disease (2).

**Objectives:** The purpose of this study was to investigate the prevalence and possible prognostic value of anti-CEP1 in patients with CTDs.

**Methods:** Two hundred and twelve consecutive patients with CTDs (51 systemic lupus erythematosus (SLE), 85 primary Sjögren’s syndrome (pSS) and 76 systemic sclerosis (SSc)) were studied and compared to 97 sex and age matched normal controls (NC) and 267 patients with RA. Anti-CEP1 IgG were detected in serum samples with a commercial ELISA kit (Euroimmun).

**Results:** The overall prevalence of anti-CEP1 in CTDs was 7% (15/212 patients). In detail, these antibodies were detectable in 4 out of 85 pSS (5%), 5 out of 51 SLE (10%) and 6/76 SSc (8%). The prevalence and the titer of anti-CEP1 in CTDs was significantly higher compared to NC and significantly lower compared to RA. Anti-CEP1 positive patients did not display a specific clinical and serological picture. Unlike in RA, anti-CEP1 did not correlate with CTD-associated ILD.

**Conclusion:** This is the first study assessing anti-CEP1 in a large cohort of patients with CTDs. We demonstrated that the association of these autoantibodies with ILD is specific for RA since it is not observed in SLE, pSS and SSc. Furthermore, although being significantly more prevalent and at higher titer compared to NC, anti-CEP1 do not allow to discriminate different patient subsets displaying peculiar clinical or serological phenotypes. Based on our results, the application of anti-CEP1 in CTDs is not advisable, however larger studies may possibly identify correlations not evident in our cohort.

**References:**


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**FR10566**

THE FLARE-RA QUESTIONNAIRE CAN IDENTIFY OMERACT FLARES IN PATIENTS WITH RHEUMATOID ARTHRITIS INCLUDED IN THE TAPERA TRIAL.

D. Bertrand1, V. Stouten1, S. Pazmino1, D. De Cock1, A. Moeyersoons2, R. Westhoven1, J. Jolly1, P. Verschueren1,2,3, ‘KU Leuven, Skeletal Biology and

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Table 1. Comparison of the total FLARE-RA scores (13q) between the disease activity groups (DAS28CRP)

<table>
<thead>
<tr>
<th>Group</th>
<th>Remission</th>
<th>LDA</th>
<th>MDA</th>
<th>HDA</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BL Patients (n)</td>
<td>62</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0.800</td>
</tr>
<tr>
<td>M3 Patients (n)</td>
<td>50</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>0.004</td>
</tr>
<tr>
<td>M6 Patients (n)</td>
<td>52</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0.057</td>
</tr>
<tr>
<td>M9 Patients (n)</td>
<td>52</td>
<td>5</td>
<td>10</td>
<td>47</td>
<td>0.079</td>
</tr>
<tr>
<td>M12 Patients (n)</td>
<td>52</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Conclusion: The FLARE-RA scores seem to reliably discern between patients with and without an OMERACT flare. A cut-off of 2.7 on the current questionnaire (r11q) had the optimal sensitivity and specificity to identify an OMERACT flare.

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