Table 1. Uno Concordance Scores. Format 'mean (min-max)'

		Baseline	Week 4	Week 8
Cox Proportional Hazards	Change 1	0.63 (0.59-0.69)	0.72 (0.68-0.80)	0.75 (0.69-0.82)
	Change 2	0.58 (0.50-0.66)	0.75 (0.65-0.87)	0.78 (0.65-0.93)
Linear Multi-Task Regression	Change 1	0.65 (0.62-0.68)	0.72 (0.68-0.78)	0.75 (0.69-0.79)
	Change 2	0.58 (0.51-0.68)	0.72 (0.67-0.82)	0.77 (0.68-0.89)
Random Survival Forest	Change 1	0.64 (0.58-0.67)	0.71 (0.66-0.78)	0.76 (0.68-0.80)
	Change 2	0.56 (0.50-0.68)	0.72 (0.60-0.82)	0.77 (0.64-0.92)

Conclusion: Our data-driven approach identified predictive clinical factors with a high face validity including joint counts, functionality scores and global health indicators. The different model approaches did not seem to increase the predictive capacity performance. However, our results underline that not so much the baseline disease status but rather the early response to initial treatment reflected in the selected predictive factors can be used for prediction of the need for further treatment adaptation. These models will have to be enriched with patient reported outcomes to further improve predictive performance.

Disclosure of Interests: None declared

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POS1435

CLINICAL CHARACTERIZATION AND PREDICTIVE FACTORS FOR PROGRESSION IN A COHORT OF ILD PATIENTS WITH FEATURES OF AUTOIMMUNITY: ARE IPAF CRITERIA SUFFICIENT?

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Background: It is unknown whether patients with interstitial lung disease (ILD) and only some features of autoimmunity have a different natural history from those with a defined connective tissue disease (CTD-ILD). The classification criteria for "ILD with autoimmune features" (IPAF) may not be able to characterize all these patients, especially those with a usual interstitial pneumonia (UIP) pattern [1].

Objectives: To determine clinical characteristics and predictive factors for progression in a cohort of ILD patients with features of autoimmunity, through the application of classification criteria for IPAF and specific CTD, whenever possible.

Methods: We retrospectively selected a cohort of consecutive patients with ILD as onset manifestation and features of autoimmunity (at least 1 autoantibody and/or 1 clinical sign/symptom), evaluated by our multidisciplinary unit from March 2009 to March 2020. All the final diagnoses were revised according to the latest CTD and IPAF criteria. Patients were followed up for 33 (16.5-69.5) months.

Results: Of the 101 patients enrolled (67.4±10.9 yrs, F/M ratio 65/36), 53 (52.5%) and 37 (36.6%) respectively satisfied the CTD and IPAF criteria. Eleven patients (10.9%) did not satisfy IPAF criteria because of only 1 item (clinical or serologic) within the IPAF domains and a UIP pattern; we defined this group as "autoimmune" UIP (AI-UIP). All the 8 patients initially classified as undifferentiated CTD had sufficient IPAF criteria. Among the IPAF patients (68.2±10.1 years, F/M ratio 20/17), the most common findings were: Nonspecific interstitial pneumonia pattern (56.8%), antinuclear antibodies positivity (43.2%) and arthritis (24.3%). The combination of a positive morphologic and serologic domain was the most common to reach the diagnosis (48.6%). Some IPAF patients had features not included in IPAF criteria, such as non-anti-synthetase myositis-specific antibodies (21.6%), objective sicca syndrome (13.5%) and anti-myeloperoxidase antibodies (2.7%). Over a median of 17 months, 2 IPAF patients (5.4%) developed a definite UIP pattern, while 4 (10.8%) a specific CTD. Comparing the IPAF, CTD-ILD and AI-UIP groups, no statistically significant differences were found in the mean age, sex distribution, smoking habits and mean duration of the disease. However, IPAF patients had a significantly higher prevalence of arterial hypertension and left-sided heart failure and a lower predominance of UIP pattern as expected (10.8% vs. 32.1% vs. 100%, $p < 0.01$). Although no differences were found at the diagnosis, at 1 year the proportion of IPAF patients with radiological progression of the fibrosis and/or functional deterioration (defined by a decline

in FVC of $\geq 10\%$ and/or DLCO of $\geq 15\%$ predicted) was lower to that of CTD-ILD and AI-UIP (17.1% vs. 31.4% vs. 63.6%, $p = 0.01$). Fewer IPAF patients needed oxygen support (8.6% vs. 31.4% vs. 36.4, $p = 0.02$). Considering the overall 101 patients, having an IPAF and a UIP pattern respectively predicted a slower (OR: 0.37, $p = 0.04$) and a faster (OR: 3.56, $p = 0.01$) ILD progression at the multivariate analysis.

Conclusion: In our cohort, IPAF criteria were useful to identify a subset of patients with a slower ILD progression and a possible evolution to CTD (10-15% of cases) [2]. These criteria do not characterize all the patients with a UIP pattern and limited features of autoimmunity, which seem to have a worse prognosis, independently from the final diagnosis. Further studies are needed to clarify if the prognosis of AI-UIP is different from that of idiopathic pulmonary fibrosis.

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POS1436

EPIDEMIOLOGY OF LATENT TUBERCULOSIS INFECTION IN PATIENTS WITH RHEUMATIC IMMUNE-MEDIATED DISEASES. SINGLE UNIVERSITY STUDY OF 1117 PATIENTS

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Background: Patients with rheumatologic immune-mediated diseases (R-IMID) with Latent tuberculosis infection (LTBI) requiring biologic therapy (BT) are at an increased risk of active tuberculosis (TB). Screening of LTBI with tuberculin skin test (TST) and/or Interferon (IFN)- γ release assays (IGRA) is recommended before starting of BT.

Objectives: In patients with R-IMID previously to BT our aim was to assess **a)** prevalence of LTBI, **b)** importance of using a booster test in negative TST and **c)** to compare TST with the IGRA test.

Methods: Cross-sectional single University Hospital study including all patients diagnosed with R-IMID who underwent a TST and/or IGRA in the last five years (2016-2020).

TST was performed by a subcutaneous injection of 0.1 ml of purified protein derivative (PPD) with a reading after 72 hours. TST was considered positive with an induration of more than 5 mm of diameter. If the first TST was negative, a new TST (Booster) was performed between 1 and 2 weeks after the first TST.

LTBI was diagnosed by a positive IGRA and/or TST and absence of active TB (Chest radiograph). Diagnosis with IGRA vs TST was compared (Cohen's kappa coefficient).

Results: We included 1117 patients (741 women/376 men), mean age 53±15 years with LTBI. Chest radiograph was normal in most of the patients, only 39 patients (3.5%) presented signs of previous TB infection, mostly granuloma. Total LTBI prevalence was 31.7% (354/1117). LTBI prevalence in different underlying R-IMID ranges from 35% in vasculitis up to 26.5% in connectivopathies (Figure 1).

Booster was positive in 66 patients (7.7%) out of 859 patients with a negative simple TST. Results of TST (+booster) and IGRA tests are shown in Table 1. TST (+booster) was positive in 187 patients (22.9%) out of 817 with a negative or indeterminate IGRA test. IGRA test was positive in 30 (3.8%) out of 793 patients with a negative TST (+booster). Cohen's Kappa coefficient between TST (+booster) and IGRA (QFT-plus), was 0.381.

Conclusion: LTBI is frequent between patients with R-IMID. Booster after negative simple TST may be useful, since it can detect false negatives for LTBI. IGRA and TST(+booster) show a low grade of agreement. Therefore, performing both tests before BT may be recommendable.

Table 1. Results of TST (+booster) and IGRA test

		IGRA (QFT-Plus)			
		Positive	Negative	Indeterminate	Unavailable
TST	Positive	89	142	45	48
	Negative	30	500	130	133
(+Booster)					
		Total	119	642	175
					181
					1117

* Cohen's kappa coefficient: 0.381