positive ANA (titer > 1/100) before the anti-TNF- α therapy were excluded. Because specific criteria for the diagnosis of DILE have not been established, we considered the diagnosis in case of a temporal relationship between clinical manifestations and anti-TNF- α treatment and fulfillment of ACR/EULAR 2019 classification criteria for SLE. In patients with DILE, clinical features, laboratory findings, systemic therapies and outcome after discontinuation of medication were collected from reuma.pt and medical records. For the clinical and demographic predictors, continuous variables were analyzed using a two-sided t-test and categorical variables using a Fisher's exact test. P-value <0.05 was considered statistically significant.

Results: In the spondyloarthritis group, 290 patients were included (44.8% females, mean age at diagnosis of 33.3 ± 11.5 years and mean disease duration of 15.1 ± 10.4 years) and in the psoriatic arthritis group, 116 patients were included (50.0% females, mean age at diagnosis of 40.1 ± 11.0 years and mean disease duration of 13.1 ± 6.8 years). In our study, we observed high serology conversion rates (positive ANA in 67.9% and 58.6% of patients with Spondyloarthritis and Psoriatic Arthritis, respectively), with similar conversion rates between different anti-TNF drugs. Three patients with spondyloarthritis (1.0%) and 1 patient with psoriatic arthritis (0.9%) developed DILE. Etanercept was the causative agent in 2 cases, infliximab and adalimumab in 1 case, each. Peripheral arthritis (new onset or abrupt worsening) occurred in 2 patients, serositis in 1 patient, constitutional symptoms in 2 patients, subnephrotic proteinuria in 1 patient, lymphopenia in 2 patients and hypocomplementemia in 1 patient. Specific treatment was prescribed to the 4 patients (oral corticosteroids) and they achieved complete recovery. After anti-TNF- α treatment interruption, no patient had recurrent disease. We observed that patients with DILE had a significantly longer disease duration (> 8.4 years; $p=0.04$) and a significantly longer duration of therapy with anti-TNF (> 4.0 years; $p=0.04$) when compared to patients without DILE.

Conclusion: Despite the frequent induction of autoantibodies, the development of DILE secondary to anti-TNF- α agents is rare. Our study demonstrates an incidence rate similar to other studies reported before. The clinical and laboratorial characteristics of our patients with DILE attributable to anti-TNF- α agents differ significantly from DILE due to more traditional agents, as is described in literature. Overall, patients in this study had mild disease that improved after therapy discontinuation, without recurrence of the disease. It seems that a longer disease duration and a longer period under anti-TNF- α therapy may increase the risk of DILE development.

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AB0328

CLINICAL AND SEROLOGICAL DIFFERENCES BETWEEN PRIMARY SJOGREN'S SYNDROME PHENOTYPES

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Background: Primary Sjogren's Syndrome (PSS) is an autoimmune and lymphoproliferative disease with a heterogeneous presentation. It has been postulated that there may be different phenotypes, in some cases presenting a more aggressive disease with systemic manifestations and a higher risk of developing complications. This phenotype has been associated with a higher autoimmune load and an earlier age of presentation. Furthermore, the presence of anti La + has been related to an increased risk of developing Lymphoma.

Objectives: To describe the phenotypic characteristics of seronegative PSS in a sample of patients from our practice. To compare the clinical and laboratory characteristics between patients with Ro + / La + and Ro + / La- antibodies. To Analyze if there are differences in patients diagnosed at an early age, compared to a later age.

Methods: Clinical and serological characteristics of patients with the diagnosis of PSS were collected from the Rheumatology database of León's Hospital between 2014-2020. All patients who met the ACR / EULAR 2016 criteria were classified as seronegative Sjogren.

In the group of patients with positive autoimmunity, anti-Ro + / La + were compared with the anti-Ro + / La- patients and by age, stratifying them into the following groups: 0-49; 50-69 and > 70 years. The clinical variables analyzed were: glandular inflammation, Raynaud's phenomenon (RP), pulmonary and

neurological involvement, presence of Lymphoma and other tumours. The serological variables were: positivity of ANA, Rheumatoid Factor (RF), hypocomplementemia, hypergammaglobulinemia and B2 microglobulin.

Results: 72 patients were analysed, 9 were excluded because didn't meet the criteria. Of the remaining: 90.4% were women, with a mean age of 58.7 ± 15.8 years, 12.6% (8) were seronegative. In the seronegative group 25% presented lung involvement (Lymphoid Interstitial Pneumonia), 50% presented with glandular inflammation and only one patient had RP. As complications 1 patient presented Lymphoma and 1 Breast Carcinoma.

58.7% (37) Ro + / La + and 28.5% (18) Ro + / La- patients were identified, no statistically significant differences were found between the two groups when comparing: glandular inflammation (8/37 vs 2/18, $p = >0.05$) RP (9/37 vs 4/18, $p = >0.05$), pulmonary involvement (5/37 vs. 6/18, $p = >0.05$), neurological involvement (2/37 vs. 1/18, $p = >0.05$), presence of Lymphoma (2/37 vs. 0 / 18, $p = >0.05$), other tumours (2/37 vs 3/18, $p = >0.05$), ANA positivity (36/37 vs 16/18, $p = >0.05$), Hypocomplementemia (4/37 vs 3/18, $p = >0.05$) and Hypergammaglobulinemia (20/37 vs 10/18, $p = >0.05$). But a higher frequency of positive RF linked to anti La positivity (29/37 vs 6 / 18 $p = 0.002$) was found.

When comparing by age groups, the association between RF + and La + remained in the group of 50-69 years (15/18 vs 3/18, $p = 0.002$) while in the other age groups there were no statistically significant differences. We also observed an increasing trend of the levels of B2microglobulin in La+ patients and later age ($p=0.04$)

Conclusion: The presence of anti La + seems to be associated with other components of autoimmunity such as RF in patients with PSS, although this study did not show a relation with a higher frequency of complications or systemic disease. Also, the presence of La+ at older ages was associated with higher levels of B2 microglobulin. We didn't find differences with the other described markers of B cell reactivation. Findings differ from those found in the literature, which may be largely due to sample size.

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AB0329

HIGHER PREVALENCE OF ECHOCARDIOGRAPHIC ABNORMALITIES IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is a chronic, inflammatory, and autoimmune disease that damages vital organs such as the heart. Patients with SLE have a higher risk of developing a cardiovascular (CV) disease than the general population (1).

Objectives: The aim of this study was to compare the echocardiographic findings in patients with SLE and controls.

Methods: This was a cross-sectional, observational, and comparative study. A total of 38 patients with SLE according to the 2019 EULAR/ACR classification criteria, ≥ 18 years old and 38 matched controls by age (± 5 years) and gender, were recruited for this study. Exclusion criteria were a poor echocardiographic window, patients with a previous CV event, such as myocardial infarction, cerebrovascular event or peripheral arterial disease, and pregnant women. A transthoracic echocardiogram, including speckle tracking technique,

was performed, by two certified echocardiographers, in all study subjects. Distribution was evaluated with Kolmogorov-Smirnov test. Comparisons were done with χ^2 and Fisher's Exact test for qualitative variables, and Student's t test and Mann-Whitney's U test for quantitative variables. A p -value <0.05 was considered statistically significant.

Results: When comparing demographic characteristics there were no significant differences in age, gender, and comorbidities between SLE patients and controls. In the echocardiographic findings a significant difference was found in the left ventricular ejection fraction (LVEF), lower in SLE patients compared to controls (57.02% vs 61.89%, $p=0.001$), in the global longitudinal strain (GLS), reduced in SLE patients (-19.55% vs -22.00%, $p=0.001$), in the tricuspid annular plane systolic excursion (TAPSE), lower in SLE patients (22.00mm vs 24.00mm, $p=0.011$), in the left atrial volume index, higher in SLE patients (28.44ml/m² vs 22.29ml/m², $p=0.014$) and in the presence of mitral regurgitation, more prevalent in SLE patients (31.6% vs 10.5%, $p=0.024$) (Table 1).

Conclusion: Patients with SLE have a worse left ventricular function, evaluated by LVEF and GLS, a worse right ventricular systolic function, evaluated by TAPSE, an increased left atrial volume index and a higher prevalence of mitral regurgitation, which are associated with a higher risk of CV death. It is important to consider including a transthoracic echocardiogram as part of the CV evaluation in patients with SLE, which may result in an early detection of CV abnormalities and an opportune treatment.

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Table 1. Demographic characteristics and echocardiographic findings.

	SLE patients (n=38)	Controls (n=38)	p
Age years, median (p25-p75)	37.5 (24.5-43.2)	45.0 (24.0-50.0)	NS
Women, n (%)	34 (89.5)	37 (97.4)	NS
T2DM, n (%)	1 (2.6)	3 (7.9)	NS
HTN, n (%)	9 (23.7)	3 (7.9)	NS
Dyslipidemia, n (%)	3 (7.9)	3 (7.9)	NS
Obesity, n (%)	1 (2.6)	5 (13.2)	NS
Active smoking, n (%)	7 (18.4)	3 (7.9)	NS
Echocardiographic findings			
Left ventricle indexed mass g/m ² , median (p25-p75)	64.00 (50.66-87.09)	60.30 (52.97-76.74)	0.009
RWT, median (p25-p75)	0.37 (0.30-0.46)	0.38 (0.33-0.45)	NS
Left ventricular ejection fraction %, mean $\pm$ SD	57.02 $\pm$ 7.37	61.89 $\pm$ 5.23	0.001
Global longitudinal strain %, median (p25-p75)	-19.55 (-21.02 - -15.95)	-22.00 (-21.00 - -20.00)	0.001
Left atrium indexed volume ml/m ² , median (p25-p75)	28.44 (20.34-33.56)	22.29 (17.97-27.13)	0.014
TAPSE mm, median (p25-p75)	22.00 (20.00-24.00)	24.00 (21.00-25.00)	0.011
Valvular abnormalities			
Aortic regurgitation, n (%)	2 (5.3)	1 (2.6)	NS
Mitral regurgitation, n (%)	12 (31.6)	4 (10.5)	0.024
Tricuspid regurgitation, n (%)	16 (42.1)	17 (44.7)	NS

SLE, systemic lupus erythematosus; NS, not significant; T2DM, type 2 diabetes mellitus; HTN, hypertension; RWT, relative wall thickness; TAPSE, tricuspid annular plane systolic excursion.

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AB0330

ANTIPHOSPHOLIPID ANTIBODIES AND ANTICOAGULANT TREATMENT: CAPILLAROSCOPIC FINDINGS

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Background: Antiphospholipid syndrome (APS) is an autoimmune condition characterized by arterial and/or venous thrombosis and/or obstetric morbidity, associated with the presence in the serum of antiphospholipid antibodies (aPL) [1]. Subjects with confirmed positivity of aPL in absence of thrombotic/obstetric manifestations are identified as aPL carriers [2]. The microangiopathy detected by nailfold videocapillaroscopy (NVC) in APS and in aPL-carrier patients is poorly investigated, as well as the possible interference of anticoagulant drugs [3].

Objectives: To compare microvascular damage in APS, aPL carriers and a group of patients (CTR) without aPL positivity and on regular warfarin therapy for cardiovascular indications

Methods: NVC investigations were performed as part of standard procedures in APS patients (18, mean age 50.0 $\pm$ 12.8 years), aPL carriers (24, mean age 46.4 $\pm$ 16.4 years) and CTR without aPL (18, mean age 74 $\pm$ 12.5 years) in therapy with oral anticoagulant (warfarin) for non-immunological vascular complications (atrial fibrillation, mechanical heart valve, deep venous thrombosis). Only patients affected by primary APS form were selected from data files (2006 Sapporo classification criteria). The following NVC parameters were available: dilated capillaries, giant capillaries, microhemorrhages (with particular attention to linear and thin hemosiderin deposits, arranged perpendicularly and parallel to the nailfold bed, "comb-like"), abnormal shape (i.e. branched "bushy" capillaries) and capillary number reduction. Those parameters were scored according to a semi-quantitative scale [4,5]. Statistical analysis was performed by non-parametric tests. Any p values equal or lower than 0.05 was considered statistically significant.

Results: APS patients showed a higher score for dilated capillaries ($p=0.001$), more frequent microhemorrhages ($p=0.03$), in particular "comb-like" microhemorrhages ($p=0.007$) than simply aPL carriers. Of note, there wasn't a statistically significant difference in the number of microhemorrhages between APS and CTR group ($p=0.23$), but again the number of "comb-like" hemorrhages, was almost absent in the CTR group ($p=0.03$). No significant correlation was found between the different aPL subtypes and the NVC parameters.

Conclusion: APS patients showed significantly higher number of non-specific NVC abnormalities than aPL carriers. Anticoagulant treatment could represent a further risk factor for the appearance of microhemorrhages in all the patients, being the NVC "comb-like" pattern mainly associated with the APS. Further investigations with larger cohorts of patients are needed for the definition of a possible APS specific NVC-pattern.

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