varying dose regimens, cumulative doses and observation periods, lack of data on potential predictors of RTM therapy response do not allow univocal conclusions on RTM efficacy or definitive recommendations on RTM use in the patients with SSc. Objectives: The study of potential efficacy predictors of anti-B-cell therapy in the patients with SSc associated with ILD.

Methods: 90 patients with SSc-ILD verified by multipolar computed tomography were enrolled to the study and received RTM therapy for 12-42 months at cumulative dose 2.9±1.1 grams (disease duration 5.9±4.8 years, diffused/limited SSc 1.3±1, average age 47 ± 13.6 years, females 83%). All patients received low or medium dose glucocorticoids. 46 patients received RTM in addition to immuno-suppressive therapy (cyclophosphamide and mycophenolate mofetil) because of inadequate efficacy of immuno-suppressants. After evaluation of FVC trends in the patients receiving RTM the overall study population was divided into two patient groups for the analysis: group A (n=35) comprised the patients with ≥10% FVC increase (disease duration 6.1±6.8 years, diffused/limited SSc 1.3±1, average age 50±12 years, females 86%, cumulative RTM dose 3.2±1.24 grams), and group B (n=11) comprised the patients with ≥5% FVC decrease (disease duration 5.2±4, diffused/limited SSc 0.8±1, average age 43±16, females 72%, cumulative RTM dose 2.5±0.99 grams). Subsequently correlation analysis was made to clarify the association between delta FVC and a number of clinical, age, gender, duration and form of SSc, modified skin count, presence of gastroesophageal reflux, mPAP, SSc activity (EScSG, points), cumulative RTM dose, immunosuppressive therapy and laboratory parameters (ESR, ANA-HEP-2, a-Scl-70, CRP. B cell count).

Results: In the overall patient population RTM therapy was associated with significant FVC increase from 77.0±19.9 % to 84.7±20.9% (p=0.000000), with median FVC increment 6.6% [0;14.1]. In group A FVC increased from 75.3±19.9 to 94.3±20.4 (p=0.000000), with median FVC increment 16.3 [12.6; 24.7]. In group B FVC decreased from 82.5±23.2 to 72.3±19.4 (p=0.000176), with median FVC decrement 10.4% [-13.4; -6].

Conclusion: Therefore, older patients who received the cumulative rituximab dose more than 3 grams with suppressed SSc activity achieved greater FVC increase at the background of therapy. These data allow to consider the above parameters as potential predictors of response to anti-B-cell therapy in the patients with SSc-ILD.

Disclosure of Interests: None declared

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Figure: (A and B) Molecular typing of patients with DM based on ferroptosis-related gene expression profiles consensus clustering of GEO samples by NMF. Comparison of ferroptosis score levels between the two subgroups of the training set(C) and the validation set(D). (E) Comparison of the ssGSEA scores between different score groups. The scores of 22 immune cells are displayed in boxplots. *p < 0.05; **p < 0.01; ***p < 0.001.

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Figure: (E) The biological process of ferroptosis is associated with the level of Tregs, suggesting the process of ferroptosis may be involved in the disease progression of DM. Identifying ferroptosis-related features for DM might provide a new idea for clinical treatment.

REFERENCES:
Background: Interstitial lung disease associated with systemic sclerosis (ILD-SSc) is a frequent manifestation of the disease, impairing the quality of life and the prognosis of the disease. The efficacy of rituximab (RTX) in patients (pts) with ILD-SSc has been shown in multiple studies [1,2]. The aim of this study was to assess the effect of ACB in the treatment of ILD-SSc, to determine if ACB can be used as a concomitant therapy. Pts received two courses of ACB with the same immunosuppressants and 4(20%) of them continued to take mycophenolate mofetil as a concomitant therapy. Pts received glucocorticoids in low doses, 10 (50%) pts were previously treated with immunosuppressants and 4(20%) of them continued to take mycophenolate mofetil as a concomitant therapy. Pts received two courses of ABC with the same scheme: 1 g repeated 1 week apart (4g ACB in total). An assessment of basic measurements was obtained at baseline (Point 0), before the second course (after 7±1.7 mo, Point 1) and at the end of follow-up (13.4±1.6 mo, Point 2). The results are presented in the form of mean values and standard deviations.

Methods: Twenty pts were included in prospective observational study. The pts were aged 49.7 (s.d.14) years, 14 (70%) were females, mean disease duration was 3.5±2.7 years, with diffuse subset in 11 (55%), 13 (65%) were anti-topoisomerase positive, all pts has NSIP-pattern by HRCT. All pts were naive to ACB, received glucocorticoids in low doses, 10 (50%) pts were previously treated with immunosuppressants and 4(20%) of them continued to take mycophenolate mofetil as a concomitant therapy. Pts received two courses of ABC with the same scheme: 1 g repeated 1 week apart (4g ACB in total). An assessment of basic measurements was obtained at baseline (Point 0), before the second course (after 7±1.7 mo, Point 1) and at the end of follow-up (13.4±1.6 mo, Point 2). The results are presented in the form of mean values and standard deviations.

Results: We observed a gradual improvement in the main parameters from Point 0 to Point 2 (table), Importantly, that at Point 1 there were no differences in most parameters, except for Rodnan skin score (mRSS) and the absolute number of B-lymphocytes (B-lymph), but at Point 2 there were significant differences between most basic outcome measures.

Table 1. Follow-up data of ABC treatment in ILD-SSC pts

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Point 0</th>
<th>Point 1</th>
<th>Point 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>mRSS</td>
<td>12.7±5.11</td>
<td>8.25±7.72</td>
<td>6.16±5.65</td>
</tr>
<tr>
<td>FVC*, % pred</td>
<td>89.1±18.2</td>
<td>92.3±19.1</td>
<td>98.2±16.13</td>
</tr>
<tr>
<td>DLCO**, % pred</td>
<td>56.67±15.7</td>
<td>58.11±17.7</td>
<td>61.86±17.16</td>
</tr>
<tr>
<td>SHAQ</td>
<td>1.13±3.62</td>
<td>0.98±6.78</td>
<td>0.61±0.49</td>
</tr>
<tr>
<td>IgG, g/l</td>
<td>0.329±0.34</td>
<td>0.0016±0.003</td>
<td>0.00189±0.003</td>
</tr>
<tr>
<td>t-PA, absolute counts</td>
<td>92.9±0.03</td>
<td>0.012±0.003</td>
<td>0.004±0.001</td>
</tr>
<tr>
<td>DLCO, % pred</td>
<td>11.0±5.27</td>
<td>10.77±5.21</td>
<td>9.42±4.23</td>
</tr>
<tr>
<td>Glucocorticoids, mg/day</td>
<td>0.3±0.03</td>
<td>0.04±0.003</td>
<td>0.004±0.003</td>
</tr>
</tbody>
</table>

FVC - forced vital capacity % predicted, DLCO - diffusion capacity for carbon monoxide % predicted. *Of the 20 patients who received the second course, 2 (10%) dropped out the follow-up due to pregnancy (1) and lung cancer (1).

The frequency and spectrum of adverse events (AE) corresponds to the known in the treatment of RTX, most AEs were classified as mild. There were 11 (55%) of AE in 9 (45%) pts. Infections were observed in 7 (35%) pts: 4 cases of acute respiratory tract infections, 2 cases of positivity in interferon-gamma release assay and one case of otitis, cystitis, cholecystitis (9 AE in total). One pts developed low limb vein thrombosis and one - lung cancer. There were no infusion-related reactions.

Conclusion: The data from this prospective pilot study showed the effectiveness of the ACB in ILD-SSc. The clinical effect of ACB arises gradually and the baseline outcome measures reliably improve by the end of the first year. Our study have demonstrated a well-tolerated safety profile. We believe that ACB can be prescribed at SSc-ILD as a first-line drug and/or in the form of monotherapy.

REFERENCES:

Disclosure of Interests: None declared

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Background: Tocilizumab (TCZ) showed trends for improving skin fibrosis and prevented progression of lung fibrosis in patients with systemic sclerosis (SSc) in placebo-controlled randomised clinical trials (RCTs). However, safety and effectiveness of TCZ beyond these selected and enriched clinical trial populations in SSc is still unknown.

Objective: To assess safety and effectiveness of TCZ treatment compared to standard of care in SSc patients from the large, multicentre, observational, real-life EUSTAR network/database using propensity score matching.

Methods: SSc patients from the EUSTAR network/database, who fulfilled the ACR/EULAR 2013 classification criteria, with a baseline and a follow-up visit at 12±3 months, receiving TCZ or standard of care (controls), were selected. The following variables were used for the propensity score matching (1:1): age at diagnosis, gender, disease subtype, baseline modified Rodnan skin score (mRSS), forced vital capacity (FVC), and diffusing capacity for carbon monoxide (DLCO), co-therapy with immunosuppressives, disease duration, and year of treatment. Primary endpoints were mRSS and FVC at 12±3 months follow-up compared between the groups, using paired t-tests. Secondary endpoints were the percentage of progressive/regressive patients for skin and lung at 12±3 months (follow-up according to ACR/EULAR 1.2), Sensitivity analyses: assessed pre-processing decisions (selection of most recent vs. random observation for control patients with multiple suitable time intervals), as well as the matching method (optimal vs. exact matching). Missing values were addressed with 100-fold multiple imputation using chained equations. Safety data were analysed in all patients. The study including the statistical analysis plan was pre-registered at www.drks.de (DRKS-ID: DRKS00015537).

Results: We identified 93 SSc patients with TCZ and 2370 SSc patients with standard care who fulfilled the inclusion criteria. Forty nine (57.7%) of the TCZ treated patients were diffuse, eight patients were not classified, disease duration was (mean±SD) 6.3±5.2 years, their baseline mRSS was 15.05±10.85, and 76 (81.7%) received immunosuppressive therapy in addition to TCZ. Through multiple imputation and propensity score matching, 100 imputed