Methods: Retrospective single-center observational study conducted in a Spanish tertiary hospital. In patients with high clinical suspicion of IIM, a myositis immunoblot was performed including Jo1, PL-7, PL-12, EJ, SRP, Mi2, Ku, MDA-5, TIF1- γ , HMGCR, PM-Scl and Ro52 antibodies. The demographic characteristics, the risk of ILD, cancer and death were analyzed.

Results: In a cohort of 313 patients with high suspicion of IIM, 87 patients (27.8%) presented a positive MSA (MSA+ve). The mean age at diagnosis was 56.7 $\pm$ 16.9 years, with no significant differences between MSA+ve and MSA-ve ($p=0.597$). Most of the patients were women with significant differences between both groups (80.5% MSA+ve vs 68.1% MSA-ve, $p=0.030$).

IIM were classified as antisynthetase syndrome (ARS) (38%), dermatomyositis (DM) (31%), overlap myopathy (OM) (16.9%) and necrotizing myopathy (NM) (14.1%) according to the manifestations and MSA found (Jo1, PL-12, PL-7, EJ in ARS; Mi-2, MDA-5 and TIF1- γ in DM; Ku and PM-Scl in OM; HMGCR and SRP in NM). The most frequent MSA were anti-Jo1 (16.9%), TIF1- γ (15.5%), Ku (12.7%), Mi-2 (9.9%), PL-7 (9.9%), HMGCR (8.5%), PL-12 (7%), MDA-5 (5.6%), SRP (5.6%) and EJ (4.2%). The presence of Ro52 associated with other MSA was found in 20 patients (22.9%).

ILD was the most frequent manifestation (45.2% of the MSA+ve). Non-specific interstitial pneumonia (NSIP) was the most frequent ILD (39.5%), followed by usual interstitial pneumonia (34.2%). The main risk factors associated with IIM-ILD were some subtypes of the MSAs ($p<0.001$), the association of Ro52 ($p<0.001$), and older age ($p=0.027$). Among the IIM, ARS and OM ($p<0.001$) were more frequently associated with IIM-ILD. The MSAs most associated with IIM-ILD were Jo1, PL-7, PM-Scl, Ku and SRP ($p<0.001$).

Cancer was found in 9.6% of MSA+ve patients. The most frequent tumors were gynecological (37.5%), followed by gastrointestinal (25%) and breast cancer (12.5%). Factors associated with cancer were age ($p=0.010$), TIF1- γ ($p<0.001$), SRP ($p=0.004$), PL-12 ($p=0.013$), PL-7 ($p=0.047$) and HMGCR ($p=0.027$).

The mortality of these patients was 3.5%. There were no differences regarding MSA+ve/-ve ($p=0.911$). However, MDA-5 ($p=0.033$) and older age ($p=0.001$) were associated with higher mortality. There were no significant differences between the IIM classifications, the associated SAD, the presence of cancer or ILD. However, longer follow-up periods and future studies are necessary to confirm these results.

Conclusion: The use of a myositis blot allowed classifying, stratifying the risk of ILD, the risk of cancer and the risk of mortality in IIM. IIM-ILD was the most frequent complication, usually manifested as NSIP. The associated risk factors were ARS, OM, some MSAs, Ro52+ and older age. Cancer was a serious and frequent manifestation in these patients, especially in patients with TIF1- γ and other MSAs, so it is essential to know the risk factors and perform an early screening, especially in older patients.

A better knowledge of the serological profiles of IIM will provide more individualized approaches and better risk stratification, helping in the management and treatment of these patients.

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POS0876

SARCOPENIA IN MYOSITIS PATIENTS: A MARKER OF MUSCLE DAMAGE ASSOCIATED WITH HANDICAP

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Background: Myositis are systemic autoimmune rare diseases characterized by muscle inflammation and weakness. Even though the signs of active disease

have been resolved, myositis patients frequently present residual muscle weakness, decreased physical performance and sustained disability. This condition has been coined on the term "damage" (as opposed to "activity").

Sarcopenia is a frequent, progressive and generalized skeletal muscle disorder characterized by low muscle strength and mass leading to handicap, decreased quality of life and increased mortality.¹

Prevalence and significance of sarcopenia in myositis patients has never been reported.

Objectives: To study sarcopenia in myositis patients with low or no disease activity.

Methods: Adult myositis patients (2017 ACR/EULAR criteria), with disease duration greater than 12 months, creatine kinase serum level (CK) less than 500 U/L, stable medication for 6 months were enrolled. Patients with inclusion body myositis were excluded. Total (LM) and appendicular (ALM) muscle mass were measured using dual-energy X-ray absorptiometry (DXA, Hologic) and muscle grip strength was measured using Jamar dynamometer. Sarcopenia was defined according to the EWGSOP2 consensus.¹

Results: 29 patients (20 female, 68.9%), with a median age of 61 years (50.5-71) were enrolled. They suffered from dermatomyositis (DM, n=4), immune-mediated necrotizing myopathy (IMNM, n=8), anti-synthetase syndrome (ASS, n=9), scleromyositis (SM, n=8) since 4.7 years (2.8-8.3). At the evaluation, muscle strength assessed with MMT-8 was 139/150 (136-147), MMT-12 was 210/220 (204-216) and CK were 131.5 U/L (105.5-202). Four patients (13.8%) were sarcopenic. Sarcopenic patients were older (73.4 years (66.2-80.5) vs 58.7 years (44.2-79.6), $p=0.03$), with a longer disease duration (7.3 years (5.3-11.8) vs 4.3 (2.7-8.3), $p=0.1$), longer time with increased CK (449 days (169.8-954) vs 255.5 (124-872.8)), higher maximum CK values (6000 U/L (2205-7000) vs 1636 (900-4457)). They suffered from IMNM (2/4, 50%); DM (n=1) and SM (n=1), had more frequently disease-related cardiac involvement (50% vs 4%, $p=0.04$), and tended to a longer steroid therapy duration (2.4 years (0.8-5) vs 1.8 (1.3-3.9), $p=0.9$) and a higher number of immunomodulatory drugs (2.5 (2-5.3) vs 2 (2-3), $p=0.3$).

At the evaluation, sarcopenic patients were globally weaker as highlighted by lower MMT-12 (201 (196.8-206.8) vs 213 (207-217.5), $p=0.02$). Head flexo-extensors and proximal upper muscles were especially weaker (respectively, $p=0.04$ and $p=0.03$). Muscle performance was also lower in sarcopenic patients as assessed by distance covered at 6-minute walk test (6mWT, $p=0.003$) and number of squats in 30 seconds ($p=0.005$). Time to drink a glass of water was significantly longer in sarcopenics ($p=0.04$) even if any patient referred dysphagia. Health assessment questionnaire score was greater (1.4 (0.8-2) vs 0.6 (0.2-1), $p=0.04$) indicating higher handicap. LM positively correlated with MMT-8 ($p=0.5$, $p=0.01$) and MMT-12 ($p=0.5$, $p=0.004$), with number of squats in 30 seconds ($p=0.7$, $p=0.0003$) and 6mWT distance covered/lower limit ($p=0.5$, $p=0.01$). Moreover, LM negatively correlated with time to drink a glass of water ($p=0.6$, $p=0.002$).

Conclusion: Muscle mass measured by DXA is a relevant parameter for muscle damage and disability in myositis patients. Sarcopenic myositis patients represent a subgroup with important muscle damage and handicap.

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POS0877

THE EFFECT OF PLATELET INHIBITORS ON DIGITAL ULCERS IN SYSTEMIC SCLEROSIS - A DERIVATION AND VALIDATION EUSTAR STUDY

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