Results:

FeV1, FVC and DLCO were 13.3%, 17.7%, and 12% respectively, p<0.05 for all comparisons. Positivity for anti-topoisomerase antibody (Scl-70) presented an OR=24.9 (p<0.001) for ILD, while ACA and anti-CENP-B were negatively associated (OR=0.114, p=0.003 and OR=0.164, p=0.024, respectively). Pulmonary hypertension based on echocardiogram findings was reported in 18 patients (19.8%), however PAH based on right heart catheterization (RHC) was confirmed in 11 of them (12.1% of total patients). Anti-Ro52 positivity was associated with PH (OR=4.45, p=0.005) and PH-ILD coexistence (OR=5.18, p=0.002), however no association was found for ILD presence in this cohort. There was also a trend for PAH-RHC, but it did not reach statistical significance. Cardiac MRI was performed in 24 patients, and non-ischemic myocardial fibrosis (compatible with SSc involvement) was identified in 18/24. The mean disease duration in MF group was longer (8.7 ±7.3 vs 3.3 ±4.3, p=0.040). Gastrointestinal involvement seems to confer an increased risk for this complication (OR=10.0, p=0.038).

Conclusion: The estimated ILD prevalence in our study is significantly higher than the one reported in the literature. As a referral centre, the patients reaching to our department probably have worse organ involvement than the average patient of primary care setting. In addition, universal screening with a baseline HRCT and close monitoring lead to an earlier identification of this population. Anti-Ro52 has been recently reported as an independent risk factor for PAH. Our results could not verify this observation, probably due to the relatively small number of PAH patients in our study. Cardiac MRI availability and radiologist’s experience are essential for MF diagnosis. It is our belief that larger studies are necessary to evaluate this population.

REFERENCES:


Acknowledgements: NIL.

Disclosure of Interests: None Declared.

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Keywords: Lungs, Cardiovascular disease, Systemic sclerosis

G. Pellegrino1, M. D’orsi1, M. Cadar1, I. Bisconti1, D. M. Reza Beigi1, F. R. Di Ciommo1, S. Truglia1, F. Conti1, V. Riccieri1, Sapienza University of Rome, Department of Internal Medicine, Anesthesiology and Cardiovascular Sciences, Rome, Italy

Background: The low-dose acetylsalicylic acid (ASA) is often used among patients with Systemic sclerosis (SSc) in clinical practice since its use is not mentioned in any official document concerning the management of SSc [1]. Recently, a study from EUSTAR database demonstrated that anti-platelet therapy is a protective factor for digital ulcers onset, while Valentini et al associated the use of ASA with a lower incidence of primary cardiac involvement in SSc patients [2,3]. On the other hand SSc has been shown to be one of the autoimmune diseases with the highest CV risk [4]. The publication of 2022 EULAR Recommendations on cardiovascular (CV) involvement in rheumatic diseases asserting that “the use of ASA in SSc is not recommended for primary prevention” because of “data about this topic were not found” caused uncertainty to justify the use of this drug [5].

Objectives: Aim of our study was to evaluate the safety of ASA in a cohort of pts affected by SSc.

Methods: We retrospectively analyzed data from patients with SSc, fulfilling the 2013 ACR/EULAR classification criteria [6], followed in our Scleroderma Clinic, receiving ASA. Analysis included data from subjects that were not treated with ASA, as control group. Exclusion criteria were CV disorders and/or major bleeding occurred before the evaluation, treatment with ASA started before the diagnosis of SSc, Helicobacter pylori-related gastritis or other causes of gastritis not SSc-related, tumors, anticoagulant or other anti-platelet therapies. Demographic, clinical, ongoing therapies were data examined; conventional cardiovascular risk factors, instrumental and laboratory assessments were collected and the CV risk was calculated using the SCORE2 and/or SCORE2-OP [7]. All data were collected for a follow-up time variable from 2 to 10 years since ASA was prescribed. The estimated ILD prevalence in our study is significantly higher than the one reported in the literature. As a referral centre, the patients reaching to our department probably have worse organ involvement than the average patient of primary care setting. In addition, universal screening with a baseline HRCT and close monitoring lead to an earlier identification of this population. Anti-Ro52 has been recently reported as an independent risk factor for PAH. Our results could not verify this observation, probably due to the relatively small number of PAH patients in our study. Cardiac MRI availability and radiologist’s experience are essential for MF diagnosis. It is our belief that larger studies are necessary to evaluate this population.

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PB0839 SAFETY OF LOW-DOSE ACETYL SALICYLIC ACID IN PATIENTS WITH SYSTEMIC SCLEROSIS: A CROSS-SECTIONAL STUDY

Keywords: Safety, Cardiovascular disease, Systemic sclerosis

G. Pellegrino1, M. D’orsi1, M. Cadar1, I. Bisconti1, D. M. Reza Beigi1, F. R. Di Ciommo1, S. Truglia1, F. Conti1, V. Riccieri1, Sapienza University of Rome, Department of Internal Medicine, Anesthesiology and Cardiovascular Sciences, Rome, Italy

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Methods: We retrospectively analyzed data from patients with SSc, fulfilling the 2013 ACR/EULAR classification criteria [6], followed in our Scleroderma Clinic, receiving ASA. Analysis included data from subjects that were not treated with ASA, as control group. Exclusion criteria were CV disorders and/or major bleeding occurred before the evaluation, treatment with ASA started before the diagnosis of SSc, Helicobacter pylori-related gastritis or other causes of gastritis not SSc-related, tumors, anticoagulant or other anti-platelet therapies. Demographic, clinical, ongoing therapies were data examined; conventional cardiovascular risk factors, instrumental and laboratory assessments were collected and the CV risk was calculated using the SCORE2 and/or SCORE2-OP [7]. All data were collected for a follow-up time variable from 2 to 10 years since ASA was prescribed for (cases) and since the first rheumatologic visit after diagnosis was done for controls (T0). Safety data included the following variables:

- major bleeding (requiring blood transfusion and/or leading to death)
- minor bleeding
- intracranial hemorrhage
- ocular hemorrhage requiring immediate treatment
- gastroenteric tract hemorrhage
- gastroenteric tract neoplasm
- gastric ulcer

Figure: IMACS core set measures at 6 and 12 months in IIMs patients who received RTX and MMF combination treatment. * = P value < 0.05

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