ARTERIAL ISCHEMIC EVENTS AND VENOUS THROMBOSIS IN SYSTEMIC SCLEROSIS: DATA FROM A MONO-CENTRIC STUDY

Keywords: Cardiovascular disease, Comorbidities, Systemic sclerosis

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Background: Systemic sclerosis is a systemic autoimmune disease characterized by vasculopathy (Raynaud phenomena), pulmonary arterial hypertension (PAH), and renal crisis, fibrosis of skin and visceral organs (notably the gut, heart, and lungs), and musculoskeletal inflammation (joints, muscles, and tendons) [1]. Inflammation drives atherosclerosis and contributes to cardiovascular (CV) disease [2]. A few studies have examined the incidence of individual macrovascular manifestations such as myocardial infarction, stroke, peripheral artery disease, and venous thromboembolism [3-4-6].

Objectives: Our aim to estimate the incidence and the arterial ischemic events and venous thrombosis rates of SSC in our database. We also investigated underlying the classical risk factors for venous thromboembolism (VTE) unprovoked (deep venous thrombosis and pulmonary emboli not associated with cancer, recent surgery, hospitalization, fracture and pregnancy) and ASCVD (myocardial infarction and stroke).

Methods: In a retrospective cohort of SSC patients between 2005 and 2017, arterial ischemic events (myocardial infarction, ischemic stroke), venous thrombosis, risk Factor (Hyperlipidemia, Smoking, Diabetes, hypertension, abdominal obesity), classical risk factors for venous thromboembolism, as well as cardiac, cutaneous and immunological characteristics were assessed.

Results: The study population comprised 212 patients (86 % female) with a diagnosis of SSC. We identified a total of 7 (3%) and 26 (12%) patients have respectively an only arterial ischemic events or venous thrombosis, and 6 (3%) additional patients have both arterial and venous thrombosis, with an event during median 10(5-34) and 6 (0-55) years of follow-up. Venous thrombosis (VT) is present in 26 patients (12 %), active or historic neoplasia is present in 4 patients (15%) of VT. In comparison of patient without VT, 20 patients (11%) have a neoplasia. Arterial ischemic events are also most frequent in female sex n=6 (86 %) with all patients (100%) have a limited sclerosis, antinuclear antibodies and Raynaud phenomena, but no difference with the control group without thrombotic events. The prevalence of most cardiovascular disorders was found to be higher in the SSC with limited sclerosis than in diffuse sclerosis. The tobacco use, alcohol is not associated of increase risk of thromboembolic events. The presence of other autoimmune tissue disorders is not significant (p=0.0003) associated of increase rate among patients with SSC with thrombotic events than without. Further adjustment for medications (aspirin, NSAIDs, glucocorticoids, statins, oral anticoagulants, and platelet inhibitors) and comorbidities yielded results similar to the main analyses, except for ischemic stroke.

Conclusion: In this monocentric study, SSCs was associated with greater risks of venous thrombosis and ischemic events, with a mortality rate in group with arterial ischemic events. There is no significant statistic difference associated of the classical risk factors of venous thromboembolism, comorbidity and the arterial ischemic events and venous thrombosis in systemic sclerosis.

REFERENCES:

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Patients affected by idiopathic inflammatory myopathies (IIM) may suffer from comorbidities such as cancer and cardiovascular diseases, calling for optimized evaluation and additional management.[1, 2]

Objectives: We aimed to explore the prevalence and profile of comorbidities in a cohort of Indian patients diagnosed with IIM, and to explore their association with a disease subtype and autoantibodies.

Methods: Information on demographics, disease subtype and autoantibodies in Indian patients with IIM were extracted from the MyoCite dataset. Comorbidities were classified as autoimmune, cardiovascular, cancer, infections, diabetes Mellitus and others. Pearson's chi-square and Fisher's exact test were used to assess differences in the occurrence of any comorbidity between the various IIM subtypes and antibodies.

Results: Of 250 patients (F:M 3.9:1, median age 36.0 ± 15.4), the majority (110, 44.0%) were diagnosed with dermatomyositis (DM), followed by overlap myositis (OM) (59, 23.6%) and anti-synthetase syndrome (ASS) (45, 18.0%). Patients with comorbidities had a higher median age (40 ± 13.9 years) compared to patients without comorbidities (35 ± 16 years) without any statistical significance. A statistically significant increase (P<0.001) in female to male ratio was observed in patients with comorbidities (10.5:1) compared to patients without comorbidities (2.3:1). Female gender was associated with higher odds of any comorbidity (OR = 4.58; 95 CI = 2.17-9.65). Comorbidities were identified in nearly half (115, 46.0%) of the patients, with autoimmune comorbidities being the most common (72/115, 62.6%) followed by cardiovascular (38/115, 33.0%) and infections (24/115, 20.9%). Hypertension was identified as the most common comorbidity (38/115 33.0%) overall, followed by thyroiditis (26/115, 22.6%) and anti-CD3 antibodies (20/115, 17.0%).

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AB0847

COMORBIDITIES IN IDIOPATHIC INFLAMMATORY MYOPATHIES: DATA FROM THE MYOCITE COHORT

Keywords: Autoantibodies, Myositis, Comorbidities

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Background: Patients affected by idiopathic inflammatory myopathies (IIM) may suffer from comorbidities such as cancer and cardiovascular diseases, calling for optimized evaluation and additional management.[1, 2]

Objectives: We aimed to explore the prevalence and profile of comorbidities in a cohort of Indian patients diagnosed with IIM, and to explore their association with a disease subtype and autoantibodies.

Methods: Information on demographics, disease subtype and autoantibodies in Indian patients with IIM were extracted from the MyoCite dataset. Comorbidities were classified as autoimmune, cardiovascular, cancer, infections, diabetes Mellitus and others. Pearson's chi-square and Fisher's exact test were used to assess differences in the occurrence of any comorbidity between the various IIM subtypes and antibodies.

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AB0836

EFFICACY OF RITUXIMAB IN IDIOPATHIC INFLAMMATORY MYOPATHIES. EXPERIENCE ON 36 PATIENTS FROM A PROSPECTIVE MONOCENTRIC COHORT

Keywords: Myositis

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Background: Idiopathic inflammatory myopathies are a heterogeneous group of autoimmune disorders characterized by muscle inflammation frequently associated with the involvement of other organ systems. Due to variety of presentations and severity degree, treatment of inflammatory myopathies is challenging. Considering the immunopathogenic role of B cell in myositis, Rituximab (RTX), as a B cell depleting agent, could be an effective therapy in patients refractory to others immunomodulatory drugs.

Objectives: The aim of the present study is to demonstrate the efficacy of RTX for the treatment of idiopathic inflammatory myopathies in multi refractory patients. We also considered the effectiveness of a low-dose RTX as a remission-maintenance therapy.

Methods: From a monocentric cohort of patients with inflammatory myopathies, we considered all patients who have been treated with RTX (2 infusions of 1 gram, week 0-2). We also considered low-dose RTX as a single dose of 1g every 6 months. The response to RTX was considered based on physician judgement (complete CR, partial PR, no-response NR), focused on muscle and lung manifestations. Improvement in muscle involvement was based on reduction of MMT -8) of 20%.

Results: Of 36 patients with IIM who are treated with RTX, 31 (86%) were found to be responsive to a diagnosis of polymyositis, one of dermatomyositis and one of antisynthetase syndrome. Patients received a minimum of 3 infusions and a maximum of 5 infusions of low dose RTX. Therapy was administrated for an average of 3 years. All of them maintained a CR to RTX.

Conclusion: In our cohort, RTX was effective in 89% multi-drug refractory patients and the low-dose was efficacious as a maintenance therapy in all cases.

REFERENCES:

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