

Objectives: To analyze the disease phenotype of patients with anti-Ro52 and/or anti-Ro60.

Methods: Multicenter, cross-sectional study of anti-Ro52 and/or Ro60 positive patients followed at 10 Rheumatology centers from January 2018 until December 2021. Patients were categorised into 3 groups: group 1 (Ro52+/Ro60-); group 2 (Ro52-/Ro60+); group 3 (Ro52+/Ro60+). Antinuclear antibodies were evaluated by indirect immunofluorescence assay and further screened for anti-extractable nuclear antigen (ENA) antibodies. Demographics and clinical data were compared between the 3 groups, by patients' medical chart review. Univariate analysis was performed using chi-square, Fisher's exact or Kruskal-Wallis test. Subsequently, the Bonferroni test was used to identify intergroup differences (level of significance: $p < 0.0167$). Univariate logistic regression was used to calculate the odds ratio with a 95% confidence interval (CI).

Results: We included 776 patients [female: 83.1%; median age: 59 (46-71) years]. Groups 1, 2 and 3 comprised 31.1%, 32.6%, and 36.3% of the patients, respectively. Characteristics of the groups are presented in Table 1. Anti-Ro52 alone is more frequently associated with non-rheumatic diseases, older age, and men ($p < 0.05$). Among patients with CTD, the diagnosis of systemic lupus erythematosus is 3 and 2 times more prevalent in groups 2 and 3, respectively, than in group 1 [OR 2.8 (95% CI 1.60, 4.97), $p < 0.001$; OR 2.2 (95% CI 1.28, 3.86), $p = 0.007$]. In group 2, the diagnosis of undifferentiated connective tissue disease is more frequent than in the other groups. The presence of isolated Ro52+ is more frequently associated with inflammatory myositis than in group 2 [OR 0.09 (95% CI 0.01, 0.33), $p < 0.001$] or group 3 [OR 0.08 (95% CI 0.01, 0.29), $p < 0.001$]. Group 1 was also more frequently associated with arthritis ($p = 0.006$), interstitial lung disease ($p = 0.002$), and myositis ($p = 0.009$).

Table 1. Characteristics of the study population according to the groups of anti-SSA(Ro) positivity.

	Group 1 (n=241)	Group 2 (n=253)	Group 3 (n=282)	p
Age, median (IQR)	64 (52-76)	56 (44-67)	57 (44-69)	<0.001
Female, n (%)	185 (76.8)	214 (84.6)	246 (87.2)	0.005
Other anti-ENA, n (%)				
Anti-La	24 (10)	50 (19.8)	114 (40.4)	<0.001
Anti-RNP	11 (4.6)	23 (9.1)	17 (6.0)	0.115
Anti-Scl70	3 (1.2)	4 (1.6)	6 (2.1)	0.146
Anti-Jo1	7 (3)	1 (0.4)	3 (1.1)	0.070
Anti-Sm	1 (0.4)	7 (2.8)	6 (2.13)	0.098
Anti-dsDNA	11 (4.6)	39 (15.4)	37 (13.1)	<0.001
Anti-centromere	12 (5)	3 (1.2)	6 (2.1)	0.026
Lupus anticoagulant	10 (4.2)	32 (12.7)	23 (8.2)	0.008
Anti-cardiolipin	8 (3.3)	10 (3.9)	23 (8.2)	0.024
Anti- β_2 glycoprotein 1	6 (2.5)	10 (3.9)	10 (3.6)	0.736
Rheumatoid Factor	46 (19.1)	44 (17.4)	81 (28.7)	0.001
Anti-CCP	11 (4.6)	15 (5.9)	19 (6.7)	0.327
Non-rheumatologic disease, n (%)	77 (32)	35 (13.8)	30 (10.6)	<0.001
Infections	11 (14.3)	2 (5.7)	1 (3.3)	0.192
Neoplasms	22 (28.6)	3 (8.6)	6 (20.0)	0.057
Interstitial lung disease	5 (6.5)	4 (11.4)	0	0.168
Other diseases	46 (59.7)	25 (71.4)	22 (73.3)	-
Immune-mediated rheumatologic disease, n (%)	164 (68.1)	218 (86.2)	252 (89.4)	<0.001
Sjögren syndrome	92 (56.1)	88 (40.3)	150 (59.5)	<0.001
Systemic lupus erythematosus	20 (12.2)	61 (28)	59 (23.4)	0.001
Systemic sclerosis	11 (6.7)	7 (3.2)	8 (3.2)	0.150
Inflammatory myositis	15 (9.2)	2 (0.9)	2 (0.8)	<0.001
Rheumatoid arthritis	18 (11)	17 (7.8)	16 (6.4)	0.234
Undifferentiated connective tissue disease	11 (6.7)	35 (16.1)	21 (8.3)	0.004
Mixed connective tissue disease	6 (3.7)	6 (2.8)	4 (1.6)	0.406
Other diseases	9 (5.5)	8 (3.7)	10 (4.0)	-

Conclusion: Anti-Ro52+ alone is frequently found in patients with non-rheumatic diseases. In addition, anti-Ro52+ is also prevalent in patients with CTD and associated with clinical phenotypes that are different from anti-Ro60+.

REFERENCES: NIL.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

DOI: 10.1136/annrheumdis-2023-eular.1841

POS0903

DIFFUSE GENERALIZED VENULITIS AS THE PRIMARY PATHOLOGY OF BEHÇET'S DISEASE: A COMPREHENSIVE MAGNETIC RESONANCE VENOGRAPHY STUDY

Keywords: Behcet's disease

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Background: Behçet's Disease (BD) is a chronic multisystem vasculitis that manifests with recurrent oral/genital ulcerations and destructive inflammation affecting eyes, central nervous system, and blood vessels. Venous thrombosis is observed in up to 40% of patients, however pathology of vein involvement in BD is poorly characterized [1]. Recently, demonstration of wall thickening in posterior wall of common femoral vein with an ultrasound (US) was reported to be a reliable auxiliary diagnostic tool in BD. Magnetic resonance (MR) venography may give more comprehensive information about deep veins and adjacent tissues.

Objectives: In this study, we aimed to characterize vein involvement in BD and evaluate diagnostic utility of MR venography.

Methods: Sixty-five BD patients who fulfilled the International Study Group (ISG) criteria and 20 healthy control subjects were enrolled. BD patients were separated into two groups based on previous history of vascular involvement. Inferior vena cava (IVC), common iliac veins (CIV), external (EIV) and internal iliac veins (IVV), common femoral veins (CFV), femoral veins (FV), and greater saphenous veins (GSV) of BD patients and healthy controls were evaluated with MR venography and ultrasonography for the presence of pathologic features, luminal thrombi, vessel wall changes and perivascular abnormalities.

Results: 33 vascular and 32 non-vascular BD patients (mean age 39.3±11.3 years and 48 [73.8%] male) were enrolled. MR venography revealed diffuse concentric thickening of the walls of IVC, CIV, EIV, IIV, CFV, FV and GSV in BD (healthy controls vs BD $p < 0.05$ for all the vein segments). (Table 1). There was no significant difference between vascular and non-vascular BD groups in terms of vein diameter and wall thicknesses, while both groups had significantly thicker veins than healthy controls ($p < 0.05$). US examination revealed similar results. MR venography provided additional information about veins and perivascular tissues like contrast enhancement, enlarged lymph nodes and seminal vesicle vascularization which were significantly more frequent in vascular BD than non-vascular BD and healthy controls.

Conclusion: The results of our study suggest that the involvement of the venous system is diffuse and generalized in BD, and demonstration of venulitis might help diagnose the disease. Further studies are needed to elucidate prognostic role of wall thickening, venulitis, in terms of anticipation of future thrombosis and treatment response.

REFERENCE:

[1] Y. Ozguler, M. Melikoglu, F. Çetinkaya, *et al.* The clinical course of the acute deep vein thrombosis of the legs in Behçet's syndrome Ann Rheum Dis.

Table 1. Comparison of magnetic resonance (MR) venography findings with respect to vascular and non-vascular involvements of Behçet's disease

	Control group (n=20)	BD all group (n=65)	BD vascular (n=33)	BD non-vascular (n=32)	p1	p2
Inferior vena cava						
Wall thickness	1.19±0.11	1.43±0.31	1.44±0.31	1.42±0.32	0.001*	0.768
Diameter	18.93±3.02	20.00±4.34	20.26±5.09	19.74±3.55	0.31	0.647
Common iliac vein						
Wall thickness	0.98±0.07	1.17±0.25	1.17±0.25	1.17±0.24	0.001*	0.97
Diameter	11.88±1.50	12.31±2.33	12.74±2.42	11.87±2.20	0.33	0.14
External iliac vein						
Wall thickness	0.87±0.11	0.96±0.17	0.99±0.18	0.93±0.15	0.006*	0.16
Diameter	10.00±1.25	10.61±2.28	11.17±2.27	10.07±2.19	0.12	0.05
Internal iliac vein						
Wall thickness	0.58±0.08	0.66±0.20	0.66±0.19	0.65±0.20	0.01	0.76
Diameter	0.69±1.61	0.69±1.75	7.14±1.59	6.64±0.19	0.99	0.26
Common femoral vein						
Wall thickness	0.62±0.08	0.74±0.22	0.77±0.30	0.71±0.87	0.001*	0.28
Diameter	7.30±1.25	8.86±2.38	8.80±2.13	8.91±2.57	0.001*	0.85
Deep femoral vein						
Wall thickness	0.56±0.08	0.63±0.26	0.68±0.34	0.58±0.10	0.05	0.11
Diameter	6.42±1.49	6.67±1.56	6.79±1.55	6.53±1.59	0.53	0.54
Greater saphenous vein						
Wall thickness	0.25±0.06	0.35±0.15	0.38±0.17	0.32±0.10	0.001*	0.11

All values are mean ± SD in millimeters. p1: Control group vs BD all group, p2: BD vascular vs non-vascular involvements.

Acknowledgements: NIL.

Disclosure of Interests: None Declared.

DOI: 10.1136/annrheumdis-2023-eular.2780

POS0904

INTENSIVE TRAINING PROGRAM FOR ULTRASOUND-GUIDED MINIMALLY INVASIVE SYNOVIAL TISSUE BIOPSY PROCEDURE ON SMALL AND LARGE JOINTS IN DIFFERENT PHASES OF JOINT INFLAMMATION

Keywords: Synovium, Education, Rheumatoid arthritis