| | Baseline | 1st week | 2nd week | 1st month |
|---|---|---|---|---|
| OCT (microns), mean±SD | 415.7±177.15 | 413.3±162.9* | 388.06±158.1* | 330.8±104.2* |
| Visual acuity, mean±SD | 0.39±0.31 | 0.4±0.31 | 0.45±0.3* | 0.51±0.3* |
| Anterior chamber cells, median [IQR] | 1 [0–1]* | 0.5 [0–1]* | 0 [0–1]* | 0 [0–0]* |
| Vitritis, median [IQR] | 1 [0–2] | 1 [0–1.5] | 0 [0–1]* | 0 [0–0.5]* |

*$p<0.05$ compared with basal data.

etanercept (2), golimumab (2), rituximab (2), abatacept (3), anakinra (1) and daclizumab (1).

TCZ administration schedule was 8 mg/kg/4 weeks iv. (n=23), every 2 weeks (1) and subcutaneously 162 mg/2 weeks (1). TCZ was used in monotherapy (13) or combined with conventional immunosuppressive drugs (12). Most of intraocular inflammation parameters showed a rapid improvement after TCZ onset (Table), with corticosteroid-sparing effect (15.9±13.6 to 8.5±5.17 mg; p=0.001). Remission was achieved in 8 patients and improvement in 17. After one month of therapy, no side effects were observed.

**Conclusions:** TCZ seems a rapid effective treatment in refractory uveitic CME.

**Disclosure of Interest:** None declared

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## THU0568 PREVALENCE AND AUTOIMMUNE RHEUMATIC DISEASE IN PATIENTS WITH AUTOIMMUNE/INFLAMMATORY SYNDROME INDUCED BY ADJUVANTS ASSOCIATED TO SILICONE BREAST IMPLANT

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**Background:** Autoimmune/inflammatory syndrome induced by adjuvants (ASIA) has been associated with previous exposure to various agents such as silicone implants, which elicit chronic stimulation of the immune system against the prosthetic material and clinical manifestation of autoimmune disease. This is particularly the case in genetically susceptible hosts.

**Objectives:** The aim is to describe de prevalence, family background and main autoimmune rheumatic disease (ARD) associated to silicone breast implant (SBI).

**Methods:**

We study a cohort of 150 patients with diagnosis of ASIA associated injection of mineral oil and silicone breast implant (SBI) in a tertiary Hospital, from 2011 to 2016. All patients were evaluated for the fulfilment of ASIA criteria. We only included patients with ASIA criteria associated with SBI plus criteria for an autoimmune rheumatic disease according to The American College of Rheumatology or EULAR. We excluded patient with ASIA and without ARD.

**Results:** There were 17 women patients with mean age 42.4±15.3 years, mean disease duration of disease 8±3. The clinical manifestation post SBI appeared 8±2 years later.

The ARD were systemic sclerosis (SSc) 5, systemic lupus erythematosus (SLE) 3, rheumatoid arthritis (AR) 3, overlap syndrome 2 (SSc plus SS and SLE plus SSc, Sjogren syndrome 1, Takayasu arteritis 1, Still disease 1, antiphospholipid syndrome 1, and 3 patients also had secondary fibromyalgia. Five Patients had more than 2 autoantibodies, 4 patients had relatives with an ARD. All patients are being treated according to the ARD (steroids plus immunosuppressive 8 patients, immunosuppressive 7, and only steroids 2), in 4 patients the prosthesis were withdrawn with improvement of clinical manifestations.

**Conclusions:** We found a prevalence of ASIA associated to SBI of 11%. The main ARD were SSc, SLE and RA. In these cases of ASIA associated with SBI some had genetic predisposition to ARD. The use of SBI is not recommended in women who have a family history of ARD.

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## THU0569 TREATMENTS OF UVEITIS IN A REFERRAL MULTIDISCIPLINARY UNIT IN NORTHERN SPAIN

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**Background:** Intraocular inflammation is one of the leading causes of visual impairment and blindness. Early and appropiate treatment is mandatory for avoiding complications.

**Objectives:** To describe the treatments prescribed in a cohort of patients with uveitis in a referral multidisciplinary unit from northern Spain.

**Methods:** Retrospective analysis of clinical records of patients evaluated in the Uveitis Multidisciplinary Unit of the Complejo Hospitalario of Navarra since January 2010 until March 2015. We analyzed the demographic characteristics and treatments received in the following 3 months after first visit.

**Results:** We identified 500 patients, 50% women with a mean age of 47.9 +/- 16.4 years. The most frequent type of uveitis was anterior uveitis (65,4%), followed by posterior uveitis (17,6%), panuveitis (15,2%), and intermediate uveitis (1,8%). Considering the etiology, 31.2% were unclassifiable, followed by non-infectious systemic disease in 29.2%.During the 3-month follow-up, 904 treatments were prescribed. The most frequent treatment was ocular topical (39%), followed by immunosuppressive treatment (27%), antimicrobial (14%), other treatments (10%) and less biological (3%), surgical (3%) and finally periocular (2%) and intravitreal (2%) treatment.Topical ocular treatment: 350 patients received topical ocular treatment, which accounts for 70% of patients. Among topical ocular treatments, 15% of the samples were treated with topical steroids, 54% were topical steroids associated with another topical treatment, 2% were topical antiglaucomatous, 2% received other topical treatments and 27% of the sample did not receive topical treatment.Immunosuppressive treatment: 249 immunosuppressive treatments were prescribed. 50% of the patients received immunosuppressive treatment. Among the immunosuppressive treatments, 25% of the patients received oral steroids, 6% salazopyrine, 4% methotrexate, 5% azathioprine, 2% mycophenolate mofetil, 5% oral steroids associated with another immunosuppressant, 15% salazopyrine associated with another immunosuppressant, 1% other immunosuppressive treatment and 49% of patients did not receive any immunosuppressive treatment.Biological Treatments: 25 patients in the cohort received biological treatment, this represents 5% of patients. The biological treatment types were distributed as follows: 3% of the patients received adalimumab treatment, 1% received infliximab, 1% received other biological treatments, and 95% of the patients did not receive biological treatments.The number of treatments received per patient was analyzed and 50 patients (10%) received no treatment, 152 patients (30%) received 1 treatment, 189 patients (38%) received 2 treatments, 75 patients (15%) Had received 3 treatments, 23 patients (5%) had received 4 treatments, 9 patients (2%) had received 5 treatments and lastly 2 patients had received 6 treatments.

**Conclusions:** The majority of patients received the combination of two treatments. Topical steroids and oral steroids were the most frequent treatments used.

**Disclosure of Interest:** None declared

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## THU0570 ANAKINRA AS A SUCCESSFUL TREATMENT OF IDIOPATHIC RECURRENT PERICARDITIS: TAPER OR NOT TO TAPER? CASE SERIES AT THE UNIVERSITY OF SOUTHERN CALIFORNIA

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**Background:** Idiopathic Recurrent Pericarditis can be challenging to treat in patients unresponsive to NSAIDs, aspirin, colchicine and immunosuppressive drugs. Patients become steroid dependent and tapering precipitates recurrences.

**Objectives:** Report 2 adult cases of idiopathic recurrent pericarditis treated successfully with Anakinra.

**Methods:** Chart review of 2 patients with idiopathic recurrent pericarditis treated with anakinra at the Keck Medical Center of USC. Literature review on treatment of idiopathic recurrent pericarditis with anakinra.

**Results:** Case 1: 60-year-old Caucasian male had five episodes of idiopathic pericarditis in 2011. Serologic workup including ANA, anti-dsDNA, malignant and infectious workup was negative. Initially, patient responded to prednisone 0.4 mg/kg/day. Adding colchicine, azathioprine and methotrexate failed to prevent recurrence. Pericarditis developed whenever prednisone was tapered below 20 mg/day with bursts of CRP to 78 mg/dl. In 2012, Anakinra 100 mg sq daily resulted in immediate clinical response and normalization of CRP (1mg/dl). Prednisone and methotrexate were tapered with no recurrence. Gradually Anakinra was tapered to 3 times/week, then once a week, with no recurrence. Case 2: 37-year-old African American male had four episodes of recurrent pericarditis. He had positive ANA 1:320, but negative anti-dsDNA, anti-smith, negative infectious and malignancy workup. Initially, patient responded to prednisone 0.6 mg/kg/day and colchicine. Tapering steroids below 40 mg/day resulted in recurrent pericarditis. Sequential addition of hydroxychloroquine, methotrexate, mycophenolate mofetil, and azathioprine failed to prevent recurrence. Anakinra 100 mg sq daily resulted in prompt resolution of symptoms, normalization of acute phase reactants and allowed successful tapering of steroids. Anakinra is being slowly tapered over the past year, with no recurrence.

**Conclusions:** Idiopathic recurrent pericarditis, which requires chronic corticosteroids, should be treated by adding another immunosuppressive agent. European Society of Cardiology guidelines recommend azathioprine, cyclophosphamide, methotrexate, hydroxychloroquine, cyclosporine or mycophenolate mofetil. Anakinra has demonstrated success in treating autoinflammatory and autoimmune diseases including FMF, TNF receptor associated periodic syndrome, rheumatoid arthritis and in patients with TRAPS mutation TNFRSF1A. This represented the possibility to decrease inflammation by blocking interleukin-1. Using this rationale we treated our patients. Picco et al reported three pediatric cases treated with anakinra, where its discontinuation resulted in recurrence.