so far. Due to retrospective data we choose as outcome only treatment duration and adverse events, direct outcomes of efficacy were impossible to evaluate. Our results indicates a poor treatment duration of biologics given off label in CTDs with a relevant prevalence of adverse events and failures. It has to be underlined that our population was mainly on TNF blockers.
These data discourage the use of biologics, mainly of TNF blockers in CTDs, even if they still can be considered with caution in very selected cases after failure of the other on label medications.
Disclosure of Interest: None declared
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AB0450 THE DARK SIDE OF GLUCOCORTICOID THERAPY IN SYSTEMIC LUPUS ERYTHEMATOSUS: CAN WE DO SOMETHING ABOUT THAT?

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Background: Corticosteroids are still one of the main treatment in Systemic Lupus Erythematosus (SLE). Beside the effect on controlling disease activity, they are also implicated in damage accrual. Both patients and physicians are some time afraid to adopt a steroid free regimen when possible.
Objectives: To evaluate the knowledge and perception of patients with SLE upon glucocorticoids.
Methods: 84 patients with SLE were evaluated and data about demographic, clinical, serological characteristics or treatment were collected. Presence of steroids related side effects like hypertension, osteoporosis, cataracts or diabetes mellitus were also assessed. All patients completed a questionnaire in order to evaluate patient's knowledge about steroids. They were asked if they had a discussion with the doctors about corticotherapy and side effects related to them, if they consider that this treatment could be stopped with specialist approval. Statistics was performed with SPSS program.
Results: All patients had treatment with corticosteroids during disease evolution. 57.14% of them experienced at least one steroids related side effect. This patients were significant older: mean age at evaluation 49.50 versus 36.47 ($p<0.0001$), had a longer disease duration: mean SLE duration 9.27 versus 4.69 (p0.016), a higher mean Prednisone equivalent dose: 8.86 versus 4.71 (p 0.031), a higher mean SLICC Damage Index: 1.53 versus 0.44 (p 0.001) than patients without steroids related side effects. This complications were significantly more rare in patients that were on a steroid free regimen at the moment of evaluation versus those on a continuum steroid regimen (7.14% versus 50%, $p<0.0001$).
When patients were asked if they will stop steroids according to medical advice, almost 1/3 of patients - 28.57% - responded "no- to afraid to do that". Patients willingness to adhere to a steroid free regimen in the future according to a physician recommendation was significant more frequent in younger patients (p 0.031, r -0.235), in those with steroids initiated in less than 1 year (p 0.016, r -0.297) and in those with less damage accrual (p 0.017, r-0.267). Flare at the moment of evaluation significantly reduced this possibility, at least from the patient perspective (p0.041, r 0.224). The likelihood of a future steroid free regimen was increased by a previous discussion patient-doctor about steroids (p0.002).
Conclusions: This study clearly shows that an open discussion with our SLE patients about corticosteroids is mandatory from the beginning. Patients should be informed about possibility of a steroid free regimen when disease status permits. This will increase patient willingness to get free of steroids when possible, helping physician to limit the continuum damage accrual of SLE patients.
References:
[1] Duru N, van der Goes MC, Jacobs JWG et al, " EULAR evidence-based and consensus-based recommendations on the management of medium to high-dose glucocorticoid therapy in rheumatic diseases", Ann Rheum Dis 2013; 72: 1905–1913.
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AB0451 RIVAROXABAN VERSUS WARFARIN AS SECONDARY THROMBOPROPHYLAXIS IN PATIENTS WITH ANTIPHOSPHOLIPID SYNDROME PROTOCOL: A RANDOMIZED, MULTICENTRE, OPEN-LABEL, CLINICAL TRIAL

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Background: Long-term anticoagulation is widely used for secondary thromboprophylaxis in the antiphospholipid syndrome (APS) due to the high risk of recurrent events. Currently anticoagulation with vitamin K antagonists (VKAs) is the standard of care but have unpredictable pharmacodynamic properties that requiere monitoring for dose adjustment. Rivaroxaban, an orally active direct factor Xa inhibitor, has been shown to be effective and safe compared with warfarin for the treatment of venous thromboembolism and non valvular atrial fibrillation in major RCTs. No studies had been published in APS.
Objectives: To investigate the efficacy and safety of rivaroxaban in preventing recurrent thrombosis in patients with APS compared with warfarin.
Methods: This is a phase 3 randomized, multicenter, non-inferiority open-label RCT. 190 eligible APS patients with arterial or venous thrombotic history receiving warfarin will be stratified according the presence of SLE and venous/arterial thrombotic history and randomized (1:1) either to continue warfarin (standard of care, normalized ratio (INR) 2–3 or 2.5 to 3.5 in those with recurrent thrombotic episodes) or to switch to rivaroxaban (20 mg/day). The primary efficacy outcome is the development of any thrombotic event during the study period. Secondary efficacy outcomes include time to thrombosis, type of thrombosis (arterial or venous), overall causes of death, evaluation of a prognostic biomarker panel of recurrent thrombosis. The primary safety outcome will be major bleeding. Secondary safety outcomes include any adverse event and minor bleeding. The study has 3 years follow-up. First patient was included in March 2013 (EUDRA-CT:2010–019764–36).
Conclusions: If the study demonstrates a non-inferior anticoagulant effect compared with warfarin, this would provide sufficient supporting evidence to make rivaroxaban a standard of care for the treatment of patients with APS with previous thrombotic history.
Disclosure of Interest: None declared
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AB0452 CASE REPORT OF ALLOGENEIC UNRELATED-DONOR MESENCHYMAL STEM CELLS (MSC) INFUSION IN SJOGREN SYNDROME (SS) WITH REFRACTORY THROMBOCYTOPENIA

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Background: Intravenous MSC infusion has been reported occasionally in SS treatmen and Immune Thrombocytopenia ttreament. To our knowledge,there is rare report of allogeneic unrelated-donor intravenous MSC infusion in SS with thrombocytopenia without immunosuppresive induction of MSC transplantation.
Objectives: To report the case of a Sjogren syndrome with refractory thrombocytopenia treated with MSC infusion. To review the current literature on intravenous MSC infusion for SS.
Methods: Literature review and multidisciplinary discussion were thoroughly performed before treatment protocol was approved by institutional ethics committee and patient and family signed informed consent form.
Results: A 48 year-old female with a 2-year history of SS, manifested by severe thrombocytopenia (PLT 14–30*10E9/L, after each injection of recombinant human interleukin 11, platelets can be transiently recovered.) refractory to Methylprednisolone, methotrexate, azathioprine and cyclophosphamide received Four infusions (Once a month) of allogeneic unrelated-donor $2x10^6$/Kg MSC. After two infusiong of MSC, the PLT increased gradually to greater than 100*10E9/L. After 1 year of follow-up, Platelet counts remained normal.
Conclusions: These results suggest that mesenchymal stem cells may be a therapeutic strategy for Sjogren syndrome with Refractory thrombocytopenia patients. Larger studies are needed to validate clinical efficacy and safety and to standardize treatment protocol of MSC infusion in SS.
References:
[1] Zhang D, Li H, Ma L, et al. The defective bone marrow-derived mesenchymal stem cells in patients with chronic immune thrombocytopenia. Autoimmunity 2014, 47 (8), 519–29.
[2] Xu J, Wang D, Liu D, et al. Allogeneic mesenchymal stem cell treatment alleviates experimental and clinical Sjogren syndrome. Blood 2012, 120 (15), 3142–51.
[3] Wu M, Ge H, Li S, et al. Mesenchymal Stem Cells Immunosuppressed IL-22 in Patients with Immune Thrombocytopenia via Soluble Cellular Factors. Journal of immunology research 2015, 2015, 316351.
Disclosure of Interest: None declared
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AB0453 OFF-LABEL USE OF MYCOPHENOLATE IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN A RHEUMATOLOGY CENTER IN COLOMBIA

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Background: Immunosuppressants such as mycophenolate are widely used in people with systemic lupus erythematosus (SLE), but not all are specifically licensed by FDA, EMA (1) and in the case of Colombia the Regulatory Agency for Food and Drugs (INVIMA) has not approved it for this indication, only for the

prevention of the rejection of some transplants. Mycophenolate mofetil was found to be associated with a lower risk of toxic adverse events such as ovarian failure, alopecia and leucopenia, compared with cyclophosphamide (1).
Objectives: To describe the population of patients with SLE receiving mycophenolate during a five year period.
Methods: We conducted a retrospective observational study, extracting information from a database in our rheumatic diseases center; we reviewed the clinical record of each patient with diagnosis of SLE and receiving mycophenolate. Descriptive epidemiology was performed for each variable presented.
Results: 1989 patients were diagnosed with Systemic Lupus Erythematosus (SLE) during 2011 and 2016 and 287 were receiving mycophenolate. Regarding demographic characteristics 94% were woman and 6% men, mean age was 49 years ± 15. 41% of patients were employed, 40% were housekeepers, 11% students and 8% retired. The indication for mycophenolate was mainly for lupus nephritis 62%, SLE in overlapping with systemic sclerosis 30% and only for SLE in 8% of cases. 36% of patients received a daily dose of 2000 mg, 30% 1500 mg, 20% 1000 mg, 8% 3000 mg, 3.5% 4000 mg and 1.5% 6000 mg and 1% 500mg. The mean value for 24 hour urine protein was 792 mg/dl ± 140 and for creatinine was 0.84 mg/dl ± 0.36. In our population patients were taking mycophenolate during a median of 24 months with a minimum of 6 and a maximum of 132. In combination with mycophenolate 28% of the patients were taking corticoids, 21% hydroxichloroquine, 20% chloroquine, 17% antihypertensive drugs, 7% other medications and only 4% were taking the mycophenolate alone.
Conclusions: Despite of the absence of a license for mycophenolate for the management of Systemic Lupus Erythematosus, the use off-label of this drug continues to be frequently as an alternative and effective treatment in patients with lupus nephritis and other conditions associated to SLE.
References:
[1] National Institute for Health Care Excellence. NICE. Systemic lupus erythematosus: oral mycophenolate. England: NICE 2014.
Disclosure of Interest: None declared
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AB0454 CLINICAL AND IMMUNOLOGICAL ACTIVITY IN POLISH COHORT OF SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS TREATED WITH GLUCOCORTICOIDS

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Background: Nowadays the lupus treatment strategy is based on background therapy, immunosuppressive drugs and glucocorticoids (GC). Using minimal effective dose of GC only in flares is a recomandation for preventing complications which increase mortality.
Objectives: To evaluate SLE clinical and immunological activity in lupus patients during the standard clinical care and analyze GC treatment
Methods: We observed Polish cohort of patients with SLE 127 patients (118 female and 9 male) with average age 43±6 years, average disease duration 7,8±5,6 years. All of them were treated with oral and pulse GC and standard immunosuppressive therapies (CTX, MMF, AZT,MTX, CsA). As a background therapy 77% of these patients were on chloroquine or hydroksychloroquine. All patients were assessed according to Systemic Lupus Erythematosus Disease Activity Index assessed by SLEDAI (version 2000) and divided into 5 groups: no GC, low dose, medium dose, high dose and puls GC therapy group. Immunological activity was assessed by anti-dsDNA and C3 and C4 complements levels.
Results: In analyzed group 28 of patients wihout GC the average SLEDAI score was 7 and 50% of this pts not revealed any immunological activity. Low dose of GC was used in 50 pts with average SLEDAI score 13 and in 24 pts of this group anti-dsDNA and C3 or C4 levels upper limit were not observed. Medium dose of GC was used in 20 pts with average SLEDAI score 19 and it was contained with high immunological activity in 55% (n=11) of pts. In 27 of pts, high doses of GC including puls therapy were needed, the average SLEDAI score was very high 30 and most of pts from this group 70% were immunologicaly active.
Conclusions: In this Polish cohort lupus patients GC doses depended on lupus activity. Minimazing glucocorticoid exposure is an important part of appropriate management of lupus patients. Proper assessment of clinical and immunolgical lupus activity is critically for treatment decisions, especially for long-term GC use.
Disclosure of Interest: None declared
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AB0455 SURVIVAL OF PREDNISONE-FREE REMISSION IN SLE PATIENTS WITH SEROLOGICALLY ACTIVE CLINICAL QUIESCENT DISEASE

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Objectives: To evaluate survival of prednisone (PDN) – free remission in systemic lupus erythematosus (SLE) patients and to investigate the potential predictors of disease flares.
Methods: Inclusion criteria were: (1) Diagnosis of SLE according to American College of Rheumatology (ACR) Classification Criteria of SLE; (2) Caucasian ethnicity; (3) Clinical remission (clinical SLEDAI-2K=0) at the time of PDN-withdrawal; (4) Stop of PDN treatment between 2010 and 2016; (5) At least two visits per year between January 2010 and April 2016.
Disease activity was assessed according to SLE Disease Activity Index-2000 (SLEDAI-2K). Damage was measured by the SLICC/American College of Rheumatology Damage Index (SDI). Flares were defined according to Safety of Estrogens in Lupus Erythematosus National Assessment (SELENA)-SLEDAI criteria.
We evaluated whether gender, age, age at PDN-stop, disease duration, duration of corticosteroid therapy, duration of remission before PDN withdrawal, time to flare, SLICC/American College of Rheumatology Damage Index (SDI) – score >3, positive anti-dsDNA antibodies (abs) and-or low C3/C4, type of SLE-involvement and concomitant immunosuppressive treatment could be predictors of flare. Multivariate logistic regression analysis was run to investigate the predictors of flare. Covariates included in the analysis were all variables reaching $p<0.20$ in the univariate analyses.
Results: Among 400 patients evaluated, 104 (26%) fulfilled inclusion criteria. Baseline characteristics are reported in table 1. Twenty-two (21.2%) patients flared. Mean time to flare was 19.91±13.14 months. Types of flare were 7 renal, 7 articular, 4 cutaneous, 2 haematological, 1 serositic and 1 neurological. Variables included in the multivariate logistic regression analysis were: positive anti-dsDNA abs and-or low C3/C4, skin, articular and haematological involvement. Skin involvement resulted predictive of flare (OR 3.07, 95% CI 1.11–8.53, P 0.031) as reported in table 2.

Demographic and clinical variables in all patients and according to survival of prednisone-free remission

	All patients	Patients maintaining PDN-free remission	Patients who flared	p Value
Patients, N	104	82	22	-
Female, N (%)	91 (87.5%)	69 (84.1%)	22(100.0%)	0.046
Age in 2016, years, mean±SD	41.25±10.95	41.46±11.13	40.45±10.46	0.723
Age at PDN-stop, years, mean±SD	39.08±11.2	39.32±11.27	38.18±10.68	0.644
Disease duration, months, mean±SD	188.54±101.57	187.61±97.96	192.0±116.52	0.817
Duration of corticosteroid therapy, months, mean±SD	131.77±89.74	128.34±88.3	140.73±96.16	0.607
Duration of remission before PDN-withdrawal, months, mean±SD	36.80±33.01	38.24±34.95	31.91±23.51	0.765
Time to flare, months, mean±SD	-	-	19.91±13.14	-
SDI >3, N (%)	10 (9.6%)	8 (9.8%)	2 (9.1%)	0.925
Positive anti-ds-DNA abs and-or low C3/C4, N (%)	89 (85.6%)	68 (82.9%)	21 (95.5%)	0.138
Skin rashes, N (%)	35 (37.7%)	22 (26.8%)	13 (59.1)	0.004
Arthritis, N (%)	69 (66.3%)	51 (62.2%)	18 (81.8%)	0.084
Serositis, N (%)	16 (15.4%)	13 (15.9%)	3 (13.6%)	0.798
Glomerulonephritis, N (%)	65 (62.5%)	53 (64.6%)	12 (54.5%)	0.385
Neuropsychiatric manifestations, N (%)	10 (9.6%)	8 (9.8%)	2 (9.1%)	0.925
Vasculitis, N (%)	6 (5.8%)	4 (4.9%)	2 (9.1%)	0.452
Haematological involvement, N (%)	25 (24.0%)	17 (20.7%)	8 (36.4%)	0.128
Concomitant immunosuppressive treatment, N (%)	41 (39.4%)	32 (39.0%)	9 (40.9%)	0.872

PDN: prednisone; SD: standard deviation; SDI: SLICC/American College of Rheumatology Damage Index

Risk of flare in prednisone-free remission. Logistic regression analysis

	OR (95% C.I.)	p Value
Skin involvement	3.07 (1.11;8.53)	0.031
Articular involvement	2.75 (0.80;9.44)	0.106
Haematological involvement	1.89 (0.62;5.73)	0.261
Positive anti-ds-DNA abs and-or low C3/C4	3.17 (0.37;27.05)	0.292

OR: Odds Ratio; C.I.: Confidence Interval

Conclusions: In SLE patients who stopped corticosteroid therapy, previous skin involvement resulted to be a predictor of disease flare.
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AB0456 SAFETY AND RETENTION RATE OF BELIMUMAB: DATA FROM A MULTICENTRIC ITALIAN STUDY

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Background: Belimumab is used in the treatment of systemic lupus erithematosus (SLE), but few data on its safety in daily clinical practice are available to date.
Objectives: To investigate safety, retention rate (RR), reasons and predictors of belimumab discontinuation in a prospective multicentric Italian study.
Methods: A total of 188 active SLE patients refractory to standard therapy were treated with belimumab as add-on-therapy in 11 Italian centers. Adverse events (AEs) were defined as “any untoward medical occurrence in a patient