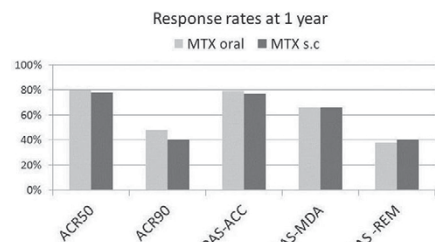


followed by by extended oligoarthritis (27%/26%), polyarticular psoriatic arthritis (18%/16%) and RF positive polyarthritis (5%/8%). Disease duration (2.3+/-3.0 vs 1.9+/-2.7 was statistically higher in the oral cohort ($p=0.04$) but age at onset and baseline were similar. The baseline disease activity was higher in the s.c. cohort (JADAS10 16.5+/-7.2 compared to 14.7+/-8.2; $p<0.001$ and active joint count 9.0+/-10.1 vs. 7.4+/-7.7; $p=0.011$). The weekly MTX dosages were comparable with 13.6+/-5.4mg and 13.3+/-4.5 mg. Concomitant treatment with NSAIDs (95%/89%), oral steroids (24%/25%) or intraarticular steroids (6%/8%) were comparable.

After 12 months of treatment, 150 (38.3%) reached a JIA ACR90 with oral MTX and 131 (35%) with s.c MTX while 86 (21.8%) and 72 (19.5%) reached JADAS-remission (JADAS10 \leq 1). By Kaplan-Meier- analysis no difference in the early kinetic of response was found. Upon total observation for up to 7.5 years in the intention to treat population (patients discontinuing MTX due to inefficacy or intolerance or starting a biologic were calculated as non-responders) more patients in the oral cohort reached a JADAS-remission (162; 41%) than with s.c MTX (126; 34%) which was statically borderline significant ($p=0.05$; odd's ratio 1.2 [95CI 1.0–1.8]).



JADAS-ACC= acceptable disease activity, MDA=minimal disease activity, Rem=remission

Conclusions: Data from the BIKER registry out of the clinical practice do show a high rate of JIA patients reaching a significant JIA-ACR response as well as JADAS-remission upon MTX as a sole DMARD. However, on the long term more patients with oral MTX reached JADAS remission. By Kaplan Meyer analyses we did not observe a superiority of s.c. MTX in the kinetic of response. The limitations of our analysis lie the character of a registry study, the lack of randomisation and study protocol leaving all decisions to start or to stop MTX by the responsible rheumatologist. Thus such data are preliminary and should be confirmed by randomized studies.

Disclosure of Interest: None declared

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THU0530 CHARACTERIZATION OF A COHORT OF PSORIATIC JUVENILE IDIOPATHIC ARTHRITIS PATIENTS FROM A PAEDIATRIC UNIVERSITY HOSPITAL IN SPAIN

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Background: Juvenile Psoriatic Arthritis (JPsoA) is a subtype of Juvenile Idiopathic Arthritis (JIA) present in 7% of JIA patients (1). Psoriasis is present in 0.5–1% of children. Diagnosis is often difficult, with the articular manifestations often preceding skin disease by years. Data is scarce in the Spanish population.

Objectives: Describe demographical and clinical characteristics of our cohort of JPsoA.

Methods: Descriptive, transversal study of patients attended from 1/2012–12/2016. Included were all compliers with ILAR Criteria (2) for JPsoA (Edmonton 2001). We also included the Wallace Criteria for clinical inactive disease (3) as a variable and endpoint. Data were included and analyzed using SPSS MAC 20.

Results: 31 patients were included: 18 (59%) girls, 13 (41%) boys. All Caucasian. They comprised 5% of all our JIA patients in that period. Mean age at diagnosis was 7.4 years. All were RF-; 9 (29%) ANA+; 4 (12.9%) HLA-B27+; articular onset 17 (55%) and cutaneous onset 14 (45%). 9 (29%) had Temporomandibular Joint (TMJ) symptoms: 5 (16%) had pain and 4 (12.9%) had a positive MRI for TMJ synovitis.

Plaque psoriasis 14 (45%), guttata 3 (9.6%) and 3 (9.6%) had both. Dactylitis 8 (26.6%); enthesitis 6 (19.35%). Joint disease was mainly oligoarticular 15 (48%), monoarticular 14 (45%) and polyarticular 1 (3.2%). Axial disease 4 (12.9%) at follow-up. 7 (22.5%) uveitis; 5 (77%) were ANA+. 3 (9.6%) onychodystrophia and 6 (19.3%) enthesitis.

All patients received NSAIDs; 30 (96%) methotrexate; 6 (19.3%) switched to leflunomide. 16 (51.6%) received biologic treatment and 9 (29%) more than one. Articular debutants 10 (32.2%) received biologic treatment more than the those with cutaneous onset 6 (19.35%). We report 3 (9.6%) anti-TNF/paradoxal psoriasis events.

Wallace Inactivity Criteria were achieved in 25 (80.6%), with no differences between the biologic and DMARDS groups in time up to Achieving Wallace

Criteria (TimeWall). TMJ positive MRI did have a negative effect on TimeWall with 2 (66.6%) \geq 8 yr (8, 11y) to TimeWall.

Conclusions: We describe the clinical features and demographics of a series of spanish JPsoA patients. We found more oligoarticular and monoarticular involvement and an important presence of enthesitis and dactylitis; higher frequency of uveitis than published data (22.5% vs. 10–15%). Some were ANA-, reinforcing the need for screening. More than half required biologic treatment, and several cases we needed to switch drugs. Almost 60% of the patients were girls. Articular onset was associated with more active, harder to treat disease. TMJ positive RMI was associated with longer TimeWall. However, Wallace Criteria were not achieved globally.

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THU0531 USE OF RITUXIMAB IN PAEDIATRIC RHEUMATOLOGY - EXPERIENCES FROM A SINGLE TERTIARY CENTRE

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Background: Rituximab is an anti-CD20 monoclonal antibody therapy used widely in the management of paediatric rheumatological conditions. Studies suggest that Rituximab is safe and effective in rheumatic autoimmune diseases, but data on paediatric use remains limited. Although Rituximab spares plasma cells, hypogammaglobulinaemia can still develop, leading to recurrent infections. Frequency of hypogammaglobulinaemia in children receiving Rituximab for rheumatological conditions is unknown.

Objectives: To analyse the use of Rituximab in a tertiary Paediatric Rheumatology centre over the last 15 years (2001–2015). The primary aims were to identify the number of patients who received Rituximab, the underlying diagnoses and the response to treatment. Our secondary aims were to identify the incidence of hypogammaglobulinemia associated with Rituximab use and the frequency and severity of infections. Frequency of monitoring of immunoglobulin levels, lymphocyte subsets and functional antibodies to pneumococcus were noted.

Methods: Retrospective analysis of case notes, electronic records and laboratory data of patients who received Rituximab in the paediatric rheumatology department from 2001–2015.

Results: A total of 22 patients received Rituximab (total of 1500mg/m² per cycle over 2 – 4 divided doses) during the study period. 3 were excluded due to insufficient data. Median time of commencement of Rituximab from diagnosis was 2 years 8 months. Of these, 12 patients achieved remission within 6 to 12 months. Rituximab was discontinued in the non-responders at 12 months.

Diagnosis	No of patients	Median No of cycles	Remission achieved
Polyarticular JIA	RF + 2 RF - 4	3.5	2 (100%) 0
JDM	6	3	5 (83%)
SLE	5	2	4 (80%)
Vasculitis (GPA)	2	2.5	1 (50%)

8 patients (42%) were noted to have hypogammaglobulinaemia at some point. The role of cyclophosphamide contributing to hypogammaglobulinaemia could not be excluded in 2 and a further patient is currently being investigated for an underlying primary immune deficiency. In the remaining 5 (26%) patients, we believe the low IgG levels are secondary to Rituximab, of which two needed long term Ig replacement. Overall 12 patients reported recurrent/severe infections of which 6 had low immunoglobulin levels.

Conclusions: RF+ JIA patients appear to have responded the best to Rituximab and RF- JIA patients the least (0/4), with good results in JDM and SLE subgroups (80–83%). The incidence of hypogammaglobulinaemia secondary to Rituximab in our cohort was 26%, which can be prolonged and worsen with increased number of cycles. Prior treatment with cyclophosphamide may be contributory. We suggest regular monitoring of immunoglobulin levels and lymphocyte markers on all patients prior to commencement of Rituximab and regular intervals subsequently, including further cycles.

Disclosure of Interest: None declared

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