gent surgery. These may be observed in polyarteritis nodosa, cryoglobulinemic vasculitis, eosinophilic granulomatosis with polyangiitis and other AAV. High-dose glucocorticoids and cyclophosphamide are usually applied.Children with IgA vasculitis may develop bowel intussusception
Deep venous thrombosis and pulmonary embolisms are significantly more frequent in AAV and Behçet disease than in the general population, especially during active disease. Anti-coagulation may be needed in AAV, although this approach is controversial in Behçet's disease. By contrast, aneurysm formation is typical in polyarteritis nodosa and Behçet's disease and may be occasionally seen in AAV. Massive bleeding derived form aneurysm rupture usually requires arterial embolization.
It is important to keep in mind that during the early course of diagnosed vasculitis, intense immunosuppressive therapy may favour life-threatening infections including opportunistic infections such as pneumocystis jiroveci pneumonia or disseminated CMV.
In summary, systemic vasculitis may present with a variety of severe complications and other may develop during follow-up. These complications are heterogeneous, vary according to the size of vessels involved, and usually require specific procedures or treatments in addition to immunosuppressive therapy. Due to the life-threatening nature of these complications their immediate recognition and management are crucial to patient survival.
Supported by SAF 577–8R and Marató TV3 2014/201507
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7166

FRIDAY, 16 JUNE 2017

AxSpA: From bug to gut and to disease phenotype –

SP0111 INHIBITING BONE FORMATION IN THE CLINIC. ARE WE THERE YET?

R. Landewe. *Rheumatology& immunology, Amsterdam Rheumatology & immunology Center, Amsterdam, Netherlands*

One of the most characteristic features of axial spondyloarthritis (axSpA) is bone formation in the spine (syndesmophytes). Syndesmophytes may occur at any time during the course of the disease, are more frequent in patients with radiographic axSpA (AS) than in those with non-radiographic axSpA, and are best seen on conventional X-rays of the spine. Currently, it is suggested that (low-radiation) CT-scanning of the spine provides a better (more sensitive) picture of developing syndesmophytes than conventional X-rays.
Syndesmophytes matter in that they interfere with spinal mobility and physical function independent of inflammation. As such, it makes sens to try and prevent their occurrence or to inhibit their progression.
It is a matter of debate whether current available treatments are able to inhibit syndesmophyte growth or occurrence. Part of the debate is the methodological challenges related to measuring syndesmophyte progression properly.
In this lecture I will address current issues related to inhibition of syndesmophyte formation in patients with axial SpA.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7211

FRIDAY, 16 JUNE 2017

Pregnancy meets rheumatic patients

SP0112 WHICH DRUGS IN PREGNANT PATIENTS?

M. Ostensen. *Department of Rheumatology, St.Olavs Hospital, Trondheim, Norway*

Management of rheumatic disease during pregnancy starts with prepregnancy counselling.Assessment of maternal and fetal risks is necessary for adjusting therapy before and during pregnancy. The aim of therapy is to keep the disease in remission or at least at low activity throughout pregnancy.
Immunosuppressive drugs requiring withdrawal before conception are methotrexate, cyclophosphamide,and mycophenolate which are known teratogenic drugs. Other drugs like leflunomide, tofacitinib and several biological should be discontinued because pregnancy experience is at present insufficient and safety for the fetus has not been proven.Flares of rheumatic disease showing be treated immediately and with pregnancy compatible drugs.For patients with inflammatory arthritis like rheumatoid arthritis,spondyloarthritis and juvenile idioipathic arthritis disease activity during pregnancy can be controlled with antimalarials, sulfasalazine and TNF inhibitors. Women with systemic lupus erythematosus should continue basic therapy with hydroxychloroquine, and azathioprine, ciclosporine or tacrolimus added when necessary due to organ manifestations. Severe flares during pregnancy may require biologics like rituximab,abatacept,tocilizumab or Anakonda, in SLE corticoid pulses or, if life threatening, intravenous gamma globulin or cyclophosphamide.
Treatment during pregnancy demands balancing suppression of maternal disease and no harm to the child. Selecting the adequate type, the right dose and the right timing of medications for optimal care of pregnant patients remains a challenge.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7246

SP0113 PREGNANCY IN SLE: STILL CHALLENGING FETAL AND MATERNAL ISSUES

R. Fischer-Betz. *Rheumatology, Heinrich-Heine-University, Duesseldorf, Germany*

Patients with SLE are mostly young women diagnosed during their childbearing years. Several "unmet needs" in the management of reproductive health issues may impact on the decision to have children. Because of earlier recognition of disease and advances in medical treatment, family planning has gained greater importance. Concerns include the effect of pregnancy on maternal disease, the impact of disease activity on fetal health, and the safety of medications during pregnancy and breastfeeding. Preconception counselling and risk stratification (including life style, disease activity, autoantibody profile, previous vascular and pregnancy morbidity, hypertension and the use of drugs with emphasis on benefits from hydroxychloroquine and antiplatelets/anticoagulants) are essential for prevention of unwanted complications during pregnancy. Recommendations for the management of family planning and antirheumatic treatment during pregnancy and lactation have been published recently by EULAR. However, many lupus patients still do not feel that their family planning concerns are adequately addressed in current clinical practice and report that they receive inconsistent advice from the various healthcare professionals. There is a clear need for provision of up-to-date and consistent information/support to our patients.
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2017-eular.7091

SP0114 CHILDREN OF PATIENTS WITH RHEUMATIC DISEASES: ISSUES RELATED TO MATERNAL DISEASE AND TREATMENT

L. Andreoli. *Rheumatology and Clinical Immunology, University of Brescia, Brescia, Italy*

A major source of anxiety for women with systemic autoimmune diseases (SADs) who wish to become pregnant is the possible impact of maternal disease and medications on the offspring, in terms of physical and mental development. A recent multicenter survey conducted in 24 Italian Rheumatology Centers showed that more than 50% women affected by SADs restricted their family size mainly because they were afraid that children could get an autoimmune disease or could be harmed by intrauterine exposure to maternal autoantibodies and anti-rheumatic drugs (Dall'Ara, ACR abstract, Arthritis Rheumatol 2016; 68, suppl 10). Therefore, the long-term follow-up children born to mothers with SADs is a topic of major relevance for the counselling on family planning.
First of all, it should be emphasized that preterm birth and other foetal complications, such as low birth weight and babies small for gestational age, are more common in patients with systemic autoimmune diseases as compared to the general population. These conditions carry themselves an increased risk for poorer physical and neuropsychiatric development. Therefore, the prevention of foetal complications should be operated by means of close obstetrical monitoring and tight control of maternal disease activity, which would be detrimental for foetal wellbeing. In this context, the use of "safe" anti-rheumatic drugs is of paramount importance for pregnant women with SADs.
Recently, a dedicated EULAR Task Force has released points to consider for the use of anti-rheumatic drugs during pregnancy and lactation (Gotestam Skorpen, Ann Rheum Dis 2016). The work of this Task Force was focused on updating the information about the use of "conventional synthetic" (cs) DMARDs but also to provide for the first time evidence-base indications on the use of "biologic" (b) DMARDs, mainly anti-TNFalfa agents.
No significant impairment in the maturation and functioning of the child's immune system has been observed for several csDMARDs, supporting their safety of use during pregnancy (Andreoli, J Autoimm 2012).
Turning to bDMARDs, a case-control study on the long-term follow-up of children exposed in utero to anti-TNFalfa drugs showed the safety of use either until the positive pregnancy index or during the second and third trimester of gestation (Dall'Ara, EULAR abstract, Ann Rheum Dis 2016; 75, Suppl 2:493). No differences between exposed and non-exposed children were found in terms of congenital defects, developmental milestones, response to vaccinations and major health problems. No particular problems were also observed in children who were breastfed while maternal anti-TNFalfa intake. The use of anti-TNFalfa agents during breastfeeding had been proposed to women who were strongly motivated based on the following considerations: 1) these drugs are poorly or absolutely not excreted into breast milk as recently demonstrated for certolizumab pegol (Clowse, ACR abstract, Arthritis Rheumatol 2016; 68, suppl 10); 2) even this was the case, the drug will be degraded in the baby's gastrointestinal tract and absorption could not be possible.
Regarding maternal disease, major concerns are linked to fetal exposure to maternal autoantibodies, mainly anti-Ro/SSA (for the development of Neonatal Lupus) and antiphospholipid antibodies (aPL). Therefore, the evaluation of these autoantibodies with potential negative impact on pregnancy and neonatal outcome should be part of the preconception work-up of women with SADs in order to provide adequate counselling and preventative strategies (Andreoli, Ann Rheum Dis 2017).