(IQR 3.75, 4). Other than 1 Filipino 2 year old girl (patient C), all other infants were of Chinese Singaporean origin and were less than age 1 year at onset; 4 male and 1 female. All patients were found to have multiple areas of irregular, thickened vessel walls with enhancement, involving the aorta and additional medium sized arteries on Magnetic Resonance Angiography (MRA). Only patients C and F presented with prolonged fever and or less than 1 clinical feature of KD. C developed a unilateral enlarged lymph node on recrudescence of fever 1 month after the initial event. She was then found to have dilated CA (dCA) and consequently abnormal MRA. Other patients had significant KD Index scores and complete KD presentations. Of the 4 patients who received only 1 dose of IVIG; C and F had diagnosis change from atypical KD to Takayasu Arteritis and G developed rhinovirus and then rotavirus as reason for prolonged fever. Patient A received IV steroids and then Infliximab. All patients received steroids. Patients A and B both developed a psoriasiform rash post-Infliximab which resolved on follow up. Patient F and Patient B died 3 months and 17 months after diagnosis. Patient F, presented with fever, fussiness and enteritis aged 4 months. Her symptoms recurred 2 weeks after onset. Due to differential hypertension, she received an echocardiogram and subsequently MRA and cardiac catheterization. Cause of death at age 7 months was small bowel perforation with arteritis and consequent intra-abdominal sepsis. Patient B, presented with complete features of KD at age 2 months. His course was noted for recrudescence 2 weeks and 4 weeks after initial IVIG. He developed giant coronary aneurysms with abnormal MRA findings; developed myocardial infarction at age 8 months and proceeded to require a Left Ventricular Assist Device but died age 13 months from multi-organ failure. 3/6 (50%) developed aneurysms, D and F were giant. 4 surviving patients, had improvement in all vessels but continued activity in the aorta on follow up MRA, they remain on Methotrexate with no active clinical findings.

Table 1: Patient characteristics

ID	Hg* (g/dL)	WBC count (10 ⁹ /L)	Platelet count (10 ⁹ /L)	CRP (mg/L)	Time to initial MRA (weeks)	Follow up MRA (months)	Immunosuppression
A	10.8	11.3	357	130	2	20	ifx
B	8.9	24.76	595	178.4	4	8	ifx
C	9.9	15.34	532	64.4	4	8	mtx
D	9.6	26.23	270	108.3	2	died	n
E	8.6	19.99	750	175.2	1	died	ctx
F	11.7	18.54	497	142	4	6	ifx, mtx

*Hg Hemoglobin, IFX infliximab, MTX methotrexate, CTX cyclophosphamide

Conclusions: Extensive involvement of the systemic arteries and aorta in all patient were noted on initial MRA. Follow up imaging, showed improvement in all vessels. After 1 year of follow up, complete resolution occurred only in medium vessels. Mortality in this patient cohort was 2/7 (28.6%). This is an observational case series and our findings will need to be reproduced in larger groups of patients.

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THU0518 BIOLOGICAL THERAPY IN NON-SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS PATIENTS FOLLOWED IN ADULT RHEUMATOLOGY DEPARTMENT: HUR-BIO REAL LIFE RESULTS

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Background: Juvenile idiopathic arthritis (JIA) is the most common chronic rheumatic disorder in childhood and more than one-third of patients have active inflammation during adult years that can cause disability.

Objectives: To define the demographic and clinical characteristics of non-systemic JIA (ns-JIA) patients under biological therapy followed in adult rheumatology department.

Methods: Hacettepe University Biologic Registry (HUR-BIO) is a single center biological registry since 2005. HUR-BIO database includes demographic and clinical characteristics of patients, disease activity parameters, history of articular prosthesis. The use of biological agents in routine rheumatology practice has been approved by the Ministry of Health since 2003.

Results: In this study, 95 (72.6% women) ns-JIA patients were included. The demographic and clinical characteristics of the patients were shown in the table. The first biological agents were; Etanercept (63.2%), adalimumab (16.8%),

infliximab (12.6%) and the others 7 (7.4%). After a mean follow-up of 60 (48) months, 42 (44.2%) patients required biologic switch. The last visit HAQ scores of 75 patients were known and 16 (21.3%) patients had HAQ score ≥ 1.0 (female 15/54 vs. male 1/21, $p=0.029$). The last visit DAS-28 score of 72 patients was known and 46 (63.9%) patients had remission or low disease activity. 14 patients (14.7%) had history of articular prosthesis and were all female. Patients with history of articular prosthesis were older [39.1 ± 10.1 vs. 29.6 ± 10.3 years, $p<0.0001$], had longer disease duration [25.7 ± 6.6 vs. 17.2 ± 11.9 years, $p=0.001$] and had longer time until the biological therapy [19.6 ± 8.4 vs. 11.5 ± 11.6 years, $p=0.002$]. The time until the biological therapy of 38 ns-JIA patients diagnosed after 2003 was shorter [3.2 ± 2.9 vs. 19.4 ± 10.6 years, $p<0.001$].

Table 1. The Demographic and Clinical Characteristics of the ns-JIA Patients

	All Patients (n=95)	Female (n=69)	Male (n=26)	p
Age mean (SD)	31.0 (10.8)	32.2 (10.9)	28.0 (10.0)	0.025
Age at first symptom, mean (SD)	9.9 (5.0)	9.5 (4.0)	10.9 (4.9)	0.22
Age at diagnosis, mean (SD)	12.5 (6.7)	12.3 (7.3)	13.2 (4.5)	0.62
Disease duration (year), mean (SD)	18.5 (11.6)	19.9 (11.2)	14.6 (12.1)	0.012
Time until the biological therapy (year) mean (SD)	12.7 (11.5)	14.2 (11.5)	8.7 (11.0)	0.01
History of hip or knee prosthesis, n (%)	14 (14.7)	14 (20.3)	0	0.01
RF or anti-CCP (+), n (%)	42 (44.2)	34 (49.3)	8 (30.8)	0.11
Biological switch, n (%)	42 (44.2)	32 (46.4)	10 (38.5)	0.64
Last visit HAQ mean (SD)	0.51 (0.62)	0.62 (0.67)	0.22 (0.35)	0.005
Last visit DAS-28 mean (SD)	2.85 (1.56)	3.14 (1.47)	2.18 (1.59)	0.009

RF: romatoid factor, CCP: cyclic citrillinated peptide, ns-JIA: non-systemic JIA, HAQ: Health Assessment Questionnaire, SD: Standard deviation.

Conclusions: Structural damage and history of articular prosthesis was more common in female ns-JIA patients receiving biological therapy. Functional disability and disease activity were also higher in female patients. On the other hand, the follow-up ns-JIA patients had a good level of remission and low disease activity. The shorter duration until the time of biological treatment in patients diagnosed after 2003 indicates that both pediatric and adult rheumatologists have begun to treat these patients more effectively.

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THU0519 ETANERCEPT, ADALIMUMAB AND METHOTREXATE UTILIZATION BY JUVENILE IDIOPATHIC ARTHRITIS PATIENTS AND THE OCCURRENCE OF UVEITIS

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Background: Juvenile idiopathic arthritis (JIA) is a chronic arthritis with an onset before 16 years of age, that persists for at least 6 weeks, and has an unknown etiology.¹ Uveitis is a serious and common extra-articular manifestation of JIA, affecting 12–30% of patients (most commonly female with ANA+ oligoarthritis JIA category).^{2,3} JIA-associated uveitis can be treated with biologic disease modifying antirheumatic drugs (bDMARDs), including TNF inhibitors (TNFi) such as etanercept (ETN), infliximab (IFX), and adalimumab (ADA), after failure of first-line treatments, such as topical corticosteroids and/or conventional synthetic DMARDs (csDMARDs), such as methotrexate (MTX).² Of note, reports exist that ETN use has been associated with uveitis flares or new-onset uveitis while an observational study reported similar uveitis flare rates for both ADA and ETN.^{4,5}

Objectives: To conduct an analysis on the occurrence of uveitis in patients with JIA treated with ETN, ADA, or MTX. Combination therapy of ETN, ADA, and MTX was also assessed.

Methods: International Statistical Classification of Diseases (ICD)-9 diagnosis codes in a Truven MarketScan® claims database were used to identify JIA patients diagnosed with uveitis over a 5-year interval. The analysis assessed the proportion of JIA patients (aged 0–19 years) treated with ETN, ADA, or MTX, as monotherapy or in combination. The percentage of patients diagnosed with uveitis and the time interval for uveitis diagnosis in patients with JIA was determined.

Results: A total of 22,789 patients with JIA where included in this analysis and exhibited a mean age of 11.4 years, were predominantly female (69%), and mean JIA disease duration was 3 years. This total included 19,814 patients with chronic, or not otherwise specified, polyarticular JIA. A total of 2581 (11.3%) patients, of mean age 10.2 years, of which 73% were female, were diagnosed with uveitis. The numbers of JIA patients receiving biologic and/or MTX therapy and proportions with a uveitis diagnoses are shown in the Figure.

Conclusions: This analysis showed a similar occurrence of uveitis in JIA patients treated with ETN or ADA, either as monotherapy or in combination with MTX.

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