even more ways in which your university or school can help you to get through your day than you would think of in the first place. Without asking for help, you will never find out what is actually possible. Through communicating with a disability-spokesperson you will most likely get even greater support.

In my lecture I will talk about my own story and how I managed to finish my Bachelor Degree whilst falling chronically ill with Adult Onset Still's Disease. I will give examples on how to handle a life with chronic illness. There will be some tips on what to do when your counterpart is not as understanding as he or she should be. I will explain what I do to get me through lectures and exams.

Disclosure of Interest: None declared

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SP0040 PARENTS SUPPORT FOR CHILDREN WITH RMDS IN EDUCATION

M. Kopic. Society for Children with Immune Disease, Komenda, Slovenia

My presentation will contain situation in schools all across the Europe (at least 13 countries/results from a survey and info which I get from our Associations, members of ENCA).

It is serious situation. First I will present the problems, we, parents, are struggling with every day. I will also prepare and present possible solutions. One country is extra good in solutions and they really take good care for children with autoimmune conditions and we can learn from them. I will also present a concrete good solution.

Solutions should be used as a prepared document for all the countries. That is a goal of ENCA.

Disclosure of Interest: None declared

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THURSDAY, 14 JUNE 2018

WIN and HOT session

SP0041 WIN SESSION: WHAT IS NEW IN THE TREATMENT OF MYOSITIS?

H. Chinoy^{1,2}. ¹National Institute for Health Research Manchester Biomedical Research Centre, Central Manchester University Hospitals NHS Foundation Trust, Manchester Academic Health Science Centre; ²The University of Manchester, Manchester, UK

Much progress has been made over the last decade in the understanding of the inflammatory myopathies. It is heartening to see some of these developments now in clinical practice which is hopefully increasing the quality of care for myositis patients. This talk will summary the new upcoming treatments in myositis. However, treatment of a rare disease not only involves administering pharmacotherapeutic agents, but recognising when to treat and which poor prognostic groups required intensification. Antibody testing of the spectrum of newly identified myositis serology now allows for better stratification of patients and assists the physician with treatment, monitoring and prognosis. New EULAR/ACR criteria are available for classification to assist inclusion into clinical trials, as well as agreed definitions for minimal, moderate and major response. A better understanding of the pathogenesis has now led to randomised controlled trials now being conducted in the inflammatory myopathies, including targeting the innate immune pathway that will hopefully lead to a licensed treatment for this difficult orphan disease.

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SP0042 RECENT ADVANCES IN THE TREATMENT OF SYSTEMIC SCLEROSIS

J.M. Van Laar. Rheumatology and Clinical Immunology, University Medical Centre Utrecht, Utrecht, Netherlands

Few rheumatological diseases have seen as many false dawns as systemic sclerosis (SSc) and many drugs once hailed as promising have fallen by the wayside. Clinical trials have been plagued by poor accrual, difficulties with definitions of endpoints, clinical heterogeneity of disease manifestations and variability of disease course, resulting in inconclusive or negative trial results. Clinicians standing in the shadows of no man's land could be forgiven for not seeing the sparks of light around them. Yet our grasp of the pathological pathways operative in SSc,

consensus on endpoints and international collaboration have paved the way for clinical trials with novel antibiotic and immunomodulatory drugs (e.g. rociguat, JAK-STATi) that could change the way we treat SSc. For now we will have to stick to old friends such as methotrexate, MMF and cyclophosphamide in early diffuse cutaneous SSc, even though their clinical benefit is modest at best as shown in the ESOS study and expressed in recent guidelines.¹⁻³ Rituximab is increasingly being used based on observational studies in SSc and its proven potency in rheumatoid arthritis, but requires more robust data. Tocilizumab has shown unexpected benefit on lung function in a phase 2 trial,⁴ which if confirmed with phase 3 trial could transform the way we manage SSc-ILD. As of yet, the only proven disease modifying therapy in early progressive SSc is autologous hematopoietic stem cell transplantation, shown to be effective in two prospective, controlled randomised clinical trials (ASTIS and SCOT, conducted in Europe and North America respectively).^{5,6} Only a small group of patients qualify for this however and even fewer have access to centres with the necessary expertise. SSc continues to constitute an area of unmet need, yet progress is being made, albeit slow.

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THURSDAY, 14 JUNE 2018

Can we halt progression of structural damage in axial SpA?

SP0043 HOW TO CAPTURE CLINICALLY RELEVANT STRUCTURAL PROGRESSION IN AXIAL SPA

D. Van Der Heijde. Leiden University Medical Center, Leiden, Netherlands

Structural damage in axial SpA usually refers to the sacro-iliac (SI) joints or the spine. The classic order of the progress of structural damage is in the SI joints, followed by the spine. Consequently, in early disease assessment of structural damage should be focused on the SI joints and in established disease (i.e. in patients with radiographic sacroillitis) evaluation of the spine becomes more useful.

The most striking abnormality representing structural damage in axial SpA is bone formation, although in early phases bone destruction can also be seen. Typically, structural damage is assessed on radiographs.

For radiographs there are two frequently used scoring methods: grading of the SI joints according to the modified New York (mNY) criteria and assessment of the spine by the modified Stoke Ankylosing Spondylitis Score (mSASSS). The mNY grades range from 0–4 per SI joint, 0–8 in total. Although it is well known that reliability of mNY grading is poor, this continuous grading has recently been successfully used as an outcome measure. The mSASSS is mainly based on bone formation in the anterior vertebral corners in the cervical and lumbar spine (range 0–72). It is a reliable measure but the progression observed by mSASSS is rather modest, resulting in a minimum follow-up of two years.

Imaging of structural damage by MRI is another option. Due to the imaging of the whole spine and the three-dimensional technique this seems an attractive alternative. However, especially bone formation is very hard to assess. Fatty deposition is a typical MRI abnormality, which can be seen as an intermediate step between inflammation visible on MRI and bone formation on radiographs. However, this finding is insufficiently validated to be able to consider it as a true surrogate for structural damage.

Finally, a CT scan is a method having the advantages of MRI (whole spine, tomographic technique) but also the best capabilities of bone imaging. The big disadvantage of CT scan is the radiation dose. Recently, it became possible to make images with good image quality but acceptable radiation, the so-called low-dose CT. A validated scoring system for CT exists: the CT scoring system (CTSS). Only bone proliferation is assessed in this method. In a direct comparison with mSASSS more progression was observed over a 2 year period. This was mainly due to the progression observed in the thoracic spine.

Only structural damage assessed by the mSASSS has shown a clear relationship with outcomes that are important for patients such as function and quality of life. No data on MRI or CTSS exist. However, it is hard to describe what defines a clinically relevant progression. The interval to assess progression to assess a