past year completed an online survey. Physicians (243 pulmonologists, 203 rheumatologists, 40 internal medicine physicians) from the US, Japan, Germany, France, Italy, Spain and UK participated. ILD prevalence and treatment patterns in the US were analysed based on insurance claims from patients with ≥ 2 claims with an ILD diagnosis between 2014 and 2016 (ICD-9/10 codes) and ≥ 1 visit to a pulmonologist in the 3 years.

Results: Analysis of US claims identified 21 592 patients with autoimmune ILD. Rheumatoid arthritis ILD (RA-ILD) and systemic sclerosis ILD (SSc-ILD) were the most prevalent ILDs across all autoimmune rheumatic diseases. The course of the patient journey is summarised (figure 1). Most patients with autoimmune-associated ILD initially present to a rheumatologist or a primary care doctor. Both pulmonologists and rheumatologists play a key role in detection and diagnosis of ILD; however US claims data suggest that the former are more likely to make the diagnosis. Although there is significant inter-patient variation, diagnosis of ILD is estimated to take approximately 9–12 months after symptoms develop. In general ILD is diagnosed earlier in SSc. Management of patients with autoimmune-associated ILD is typically multidisciplinary, involving both a rheumatologist and a pulmonologist. The physician survey suggested that 24%–31% of patients with autoimmune-associated ILD develop PF-ILD; detection can take up to 1 year. The majority of physicians use corticosteroids as a first line treatment across autoimmune rheumatic diseases; cyclophosphamide and mycophenolate mofetil were the second and third first line option for SSc-ILD. Physicians estimate the total disease course in patients with autoimmune-associated PF-ILD to be approximately 5–7 years.

Abstract SAT0593 – Figure 1. Physician* Estimated PF-ILD Disease Course in patients with autoimmune rheumatic diseases

Conclusions: Physicians who manage patients with autoimmune diseases estimate that 24%–31% develop PF-ILD. Delayed referral to a pulmonologist or rheumatologist is likely to delay diagnosis and management of PF-ILD. Life expectancy for these patients is believed to be similar to patients with IPF. There is an unmet need for treatments that slow or stabilise disease progression of PF-ILD.

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SAT0594 WHICH ONE IS MORE VALUABLE FOR DIAGNOSIS OF ADULT ONSET STILL'S DISEASE? SOLELY NEUTROPHILIA OR LEUKOCYTOSIS WITH NEUTROPHILIA?

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Background: Adult onset Still's disease (AOSD) is a rare, auto-inflammatory disease that has unknown etiology and poorly defined pathogenesis. To date, there are several classification criteria, available for AOSD, but most commonly used one is proposed by Yamaguchi et al.¹ One of the major items of this set of criteria is leukocytosis with neutrophilia.

Objectives: To usefulness of solely neutrophilia instead of leukocytosis with neutrophilia for the Yamaguchi criteria.

Methods: Sixty-one AOSD patients followed at Hacettepe University department of rheumatology were included to analysis. Diagnosis of AOSD was based on physicians' decision, but Yamaguchi criteria was applied for all patients, as well. Complete blood test with differential was noted at the time of diagnosis of AOSD. One of the major criteria of Yamaguchi criteria was "leukocytosis with neutrophilia (defined as more than 80% of leukocytes would be granulocyte)". Leukocytosis [$>10000/\text{mm}^3$ x1000] and neutrophilia [(6400/ mm^3) x1000] were defined according to normal upper limits of our laboratory. To compare with Yamaguchi criteria, neutrophil/leukocyte ratio for all patients were calculated. Descriptive statistics for non-normally distributed countable data were given as median and interquartile range (Med [IQR]). $p < 0.05$ was considered as statistically significant.

Results: Total 61 patients (46 (75%) female) were recruited. Prevalence of major and minor Yamaguchi criteria were as follow: fever in all patients, arthralgia in 58 (95%) patients, rash in 43 (71%) patients, sore throat in 48 (79%) patients, lymphadenopathy and/or splenomegaly in 23 (38%) patients, absence of RF and ANA in 58 (96%) patients, elevated liver enzymes in 47 (77%) patients. Median leukocyte and neutrophil count were 13.5 (IQR;10.1–18.9) x 1000/ mm^3 , 12 (IQR;7.2–17.6) x 1000/ mm^3 , respectively. "Neutrophilia $> \text{UNL}$ " was significantly more prevalent than "leukocytosis with neutrophilia $> 80\%$ " (51 (83.6%) vs. 37 (60.6%), $p < 0.001$). Overall, 14 (23%) patients would have one more positive major criteria if "neutrophilia $> \text{UNL}$ " would be used instead of "leukocytosis with neutrophilia $> 80\%$ ". When current Yamaguchi criteria (including leukocytosis with neutrophilia $> 80\%$) applied to patients with AOSD, 57 (93.5%) of 61 patients were met the criteria. However, when "neutrophilia $> \text{UNL}$ " was used instead of "leukocytosis with neutrophilia $> 80\%$ ", all patients were met the revised criteria.

Conclusions: As all patients who had leukocytosis also had neutrophilia but it was not vice versa. In other words, choosing "leukocytosis with neutrophilia $> 80\%$ " instead of "neutrophilia $> \text{UNL}$ " can underdiagnose AOSD approximately in 7% of patients according to Yamaguchi criteria. Moreover, Physicians should be keep in mind that reactive hemophagocytosis may influence the count of leukocyte. Consequently, using "neutrophilia $> \text{UNL}$ " as a criteria instead of "leukocytosis with neutrophilia $> 80\%$ " may be more appropriate for the diagnosis of AOSD in real life.

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SAT0595 ANALYSIS OF RECURRENCES AFTER SUSPENSION OF IMMUNOSUPPRESSIVE TREATMENT IN NON-INFECTIOUS UVEITIS

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Background: Uveitis is the most common ocular inflammatory disease. According to the classification, non-infectious uveitis 70% of the total, presenting a chronic course and with it, an increased risk of complications. The phased therapeutic approach in ophthalmology is well established and is based on the efficacy of synthetic and biological immunosuppressive therapy.¹ However, we do not have evidence-based protocols that allow us to know how long to maintain them, or when to interrupt them.

Objectives: The main objective is to evaluate the free time without ocular inflammatory activity after the withdrawal of the synthetic and/or biological immunosuppressive treatment in patients with non-infectious uveitis.

As secondary objectives are collected the epidemiological and clinical characteristics, the distribution of the different immunosuppressive drugs employed and