analysed the cases of recurrence after the interruption of treatment, and the need of reintroduction.

Methods: A retrospective cohort multicenter study was conducted in patients with a diagnosis of non-infectious uveitis followed in a multidisciplinary unit, that after two or more years of ocular and extraocular inactivity, the immunosuppressive treatment was suspended. It was defined inactive uveitis as cell Tyndall 0 in anterior and vitreous chamber, as well as the absence of other signs of active inflammation (retinal infiltrates, choroid and vasculitis and/or papillitis with angiographic leakage).

Demographic characteristics, anatomical location and laterality of the uveitis, visual acuity at the beginning and end of the study and the drugs used were recorded.

Results: We analysed 48 patients with an average age at the onset of immunosuppressive treatment of 39.3 years (± 16 years). 85.4% of the uveitis were bilateral. The main diagnoses are described in table 1. In 56.3% of cases a single immunosuppressant was used. Cyclosporine was the most employed (72.9%) and methotrexate was the most used in monotherapy (83.3%). 83% of patients received corticosteroids and 12% treatment with Infliximab. The mean duration of immunosuppressive treatment was 6.9 years (± 5 , 7 años). The percentage of total and ocular recurrence was 37.5% and 31.25% respectively. The mean duration of follow-up after treatment suspension was 4.3 years (± 4.5 years), being more than 1 year in 77.1% of patients. We found that 75% of patients remained free of recurrence at least 27 months. The administration of two or more immunosuppressive drugs proved to be a risk factor for recurrence ($p=0.048$) and reintroduction of treatment after it ($p=0.008$), which was performed in 39% of the ocular recurrences. Visual acuity did not suffer variation in 78.6% of recurrences and 80.3% of those that did not recur.

Abstract SAT0595 – Table 1- Main diagnoses

Diagnosis	Female (n=29)	Male (n=19)	All (n=48)
Idiopathic uveitis (n=13)	7 (53,8%)	6 (46,2%)	13/48 (27%)
Juvenil idiopathic arthritis (n=1)	1 (100%)	0 (0%)	1/48 (2,08%)
Multifocal Choroiditis with Panuveitis (n=1)	0 (0%)	1 (100%)	1/48 (2,08%)
Serpiginous choroiditis (n=3)	1 (33,3%)	2 (66,7%)	3/48 (6,25%)
Behçet disease (n=10)	4 (40%)	6 (60%)	10/48 (20,83%)
Birdshot Retinochoroidopathy (n=5)	3 (60%)	2 (40%)	5/48 (10,41%)
Inflammatory bowel disease (n=1)	1 (100%)	0 (0%)	1/48 (2,08%)
Multiple sclerosis (n=3)	3 (100%)	0 (0%)	3/48 (6,25%)
Ankylosing spondylitis (n=1)	0 (0%)	1 (100%)	1/48 (2,08%)
HLA27 positive (n=1)	1 (100%)	0 (0%)	1/48 (2,08%)
Pars planitis (n=2)	1 (50%)	1 (50%)	2/48 (4,16%)
Sarcoidosis (n=5)	5 (100%)	0 (0%)	5/48 (10,41%)
Vogt-Koyanagi-Harada (n=2)	2 (100%)	0 (0%)	2/48 (4,16%)

Conclusions: In our cohort, patients with no ocular inflammatory activity for at least two years could benefit from the suspension of immunosuppressive treatment without a visual risk. The use of one or more immunosuppressive drugs has been identified as a risk factor for recurrence.

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SAT0596

THORACIC INVOLVEMENT AT DIAGNOSIS DRIVES A DIFFERENTIATED CLINICAL PRESENTATION OF SARCOIDOSIS: ANALYSIS OF 1245 PATIENTS (SARCOGEAS-SEMI)

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Objectives: To analyse whether thoracic involvement at diagnosis is associated with a specific clinical presentation of sarcoidosis.

Methods: The SARCOGEAS-SEMI is a nationwide registry of patients with sarcoidosis. Radiographic stages at diagnosis were classified as stage 0 (normal), stage I (only bilateral hilar lymphadenopathy -BHL-), stage II (BHL +pulmonary infiltrates), stage III (only infiltrates) and stage IV (fibrosis).

Results: The cohort consisted of 1245 patients (722 women, 523 men, mean age at diagnosis 47 years). Pulmonary imaging data at diagnosis was available in 1230 patients including 395 (32%) with stage I, 500 (40%) with stage II, 195 (16%) with stage III and 42 (3%) with stage IV. Patients with no thoracic involvement (stage 0) were more frequently women (73% vs 56%, $p=0.002$), older (52.1 vs 46.8 years, $p=0.001$) and had a higher frequency of skin (54% vs 34%, $p<0.001$) and neurological (14% vs 6%, $p=0.004$) involvements in comparison with those with stages I-IV. Patients without ILD (stage I) were more frequently women (61% vs 54%, $p=0.031$), had a higher frequency of fever (27% vs 19%, $p=0.002$), skin (43% vs 29%, $p<0.001$) and salivary gland involvement (8% vs 3%, $p=0.001$), and a lower frequency of respiratory symptoms (37% vs 54%, $p<0.001$) and liver involvement (9% vs 16%, $p=0.001$) with respect to those with ILD (stages II-IV).

Conclusions: A specific clinical and epidemiological pattern of disease presentation was found in patients with no thoracic involvement and in those presenting with interstitial lung disease at diagnosis.

Disclosure of Interest: None declared

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SAT0597

NEW AUTOINFLAMMATORY PHENOTYPE MANIFESTING AS HYPOCOMPLEMENTEMIC URTICARIAL VASCULITIS AND ASSOCIATED WITH HOMOZYGOUS AGBL3 VARIANT

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Background: Autoinflammatory disorders are primarily associated with inborn errors of the innate immune system, but some of them are also developing autoimmune features.

Objectives: To define a new autoinflammatory phenotype in a patient with inflammatory attacks manifesting as hypocomplementemic urticarial vasculitis and to identify responsible gene/pathway.

Methods: Clinical manifestations of the index case and his family history were carefully searched and blood samples were collected from the index case and his both parents. Genomic variations were screened by whole exome sequencing,

and a systematic search was carried out specifically for identification of deleterious genetic variants in genes involved in novel inflammatory pathways.

Results: The index case was coming from a consanguineous family of Assyrian origin, who is now 22-year-old male. He presented to our outpatient clinic with recurrent attacks of fever, urticarial rash on the extremities and trunk, conjunctival injections and arthralgia, without a trigger or more frequently following an infection. His attacks started when he was 13, and two to three days lasting attacks recurred more frequently during warm weather conditions or following hot baths. He had highly elevated CRP and ESR during attacks, but his acute phase response did not return to normal values in between the flares. Low C3 and C4 values were also observed during asymptomatic periods. His ANA test became positive during the course of his disease, with an increasing titer in the last year. He responded partially to corticosteroids as well as canakinumab and anakinra treatments, and he is currently on low dose steroids and 100 to 200 mg/day anakinra. Whole exome sequencing revealed a deleterious homozygous c.769C>T mutation in AGLB3 (ATP/GTP binding protein-like 3) gene, which results in early termination of the protein (p.Gln257Ter) and deletion of the functional carboxypeptidase domain. This protein belongs to metalloproteases that mediate both deglutamylation and deaspartylation of target proteins. AGLB3 is suggested to catalyse the deglutamylation of polyglutamate side chains, especially in proteins such as tubulins. Also, STRING search revealed the interaction of AGLB3 with complement regulatory proteins, such as CD46, CD55, and CD59, which are potent inhibitors of the complement membrane attack complex. We searched databases from Turkey and other sources including 1000 Genomes Project data, and we could not identify this variant in other individuals.

Conclusions: This study identifies the AGLB3 metalloprotease gene as a potential autoinflammatory gene involved in a novel pathway and possibly associated with hypocomplementemic urticarial vasculitis phenotype. Previously, DNASE1L3 mutations have been associated with hypocomplementemic urticarial vasculitis and systemic lupus erythematosus phenotype. The loss of function mutation in the AGLB3 may result in a potent innate inflammatory response as well as autoimmunity through a new pathway, which is resulting in lower complement levels and ANA positivity along with recurrent inflammatory episodes. This complex phenotype explains a partial response to the IL-1 blockade, and further studies in patients/families with a similar phenotype are needed.

Disclosure of Interest: None declared

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SAT0598 SYSTEMATIC LITERATURE REVIEW ON THE EFFICACY AND SAFETY OF IMMUNOMODULATORY DRUGS IN PATIENTS WITH NONINFECTIOUS INTERMEDIATE AND POSTERIOR UVEITIS, PANUVEITIS AND MACULAR OEDEMA

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Background: Posterior segment uveitis (PSU) is a sight-threatening condition

Objectives: To perform a systematic review of the literature on the use of immunomodulatory drugs in adult patients with non-infectious and non-malignant PSU including intermediate (IU) and posterior uveitis (PU), panuveitis (PanU) and macular oedema (ME).

Methods: Search strategies were designed for Medline, Embase, and Cochrane Library for articles with clinical, safety or cost-effectivity data up to, Jan 2017 followed by secondary search from their bibliography. Quality was assessed (Jadad/Oxford)

Results: From 1103 articles, 31 moderate quality clinical trials (CT) were selected, prospective/retrospective, with variability in mean duration, No. and patients' characteristics. PSU was treated with synthetic DMARDs methotrexate (MTX), azathioprine (AZA), cyclosporine A (CsA), cyclophosphamide (CyC), tacrolimus, sirolimus, micophenolate (MMF) and interferon β , and biologic DMARDs rituximab, adalimumab, infliximab (IFX) at usual dosages. Most common measures: visual acuity (VA), macular thickness and vitreous haze. MTX vs.MMF, was effective in IU, PU and PanU, with no differences in efficacy and adverse events (AEs), neither in Vogt-Koyanagi-Harada. MTX was effective with RTX, and SC was inferior to IFN β with lower rate of AEs in IU with cistoid ME (CME). CsA did not show efficacy vs. placebo (pbo), with more neurological AEs. Tacrolimus vs. CsA was safer with similar efficacy, and CsA was useful with no differences vs.

prednisone (pred) or vs.CsG, and similar vs.CYC at 2 y in Behçet PSU. CsA +pred + ketoconazole combined showed additional benefits. CYC+AZA were effective in PU, except for VA and retinal vasculitis, with no differences vs. RTX +MTX. CYC was useful in serpinoid choroiditis $\pm$ dexamethasone. ADA was useful in IU, PU and PanU vs. pbo. IFX in Behçet PSU, was more effective vs. prednisone +CsA + AZA/MTX. Intravitreal ADA and IFX did not show any benefit. Secukinumab vs. pbo did not prevent recurrences. In another RCT, IV route showed a higher response rate vs.SC for 30 mg/kg, with similar rate of EAs. Intravitreal bevacizumab was effective in multifocal choroiditis and CME. Intravitreal ranibizumab was useful in pigmentary retinitis +CME. Daclizumab in Behçet PSU did not show benefit vs. pbo. Tacrolimus as 2nd line in PU was effective $\pm$ pred. Intravitreal and subconjunctival sirolimus were effective in IU, PU and PanU in vitreal haze but not VA and ME, improving functional scores

Studies flow chart

Conclusions: 1 Moderate quality of evidence

2 Variability in patients, definitions and outcomes

3 Systemic DMARDs MTX, MMF, CsA, CyC, tacrolimus, sirolimus, MMF and IFN β were useful in PSU;AZA in combination

4 Biologic DMARDs ADA, IFX (systemic), ranibizumab, bevacizumab (intravitreal) were useful, daclizumab did not show efficacy. Possible efficacy of secukinumab

5 Intravitreal anti-TNF (ADA,IFX) were not useful

Disclosure of Interest: None declared

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SAT0599 IDIOPATHIC GRANULOMATOUS MASTITIS MAY RESPONSE WELL TO COMBINATION OF IMMUNOSUPPRESSIVES AND GLUCOCORTICOIDS

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Background: Idiopathic granulomatous mastitis (IGM) is a rare inflammatory disease of breast. Corticosteroids (CS) and immunosuppressive agents constitute treatment alternatives other than surgery.

Objectives: To evaluate the clinical characteristics and treatment responses of IGM patients followed up in our clinic.

Methods: The medical records of 70 IGM patients who were referred to Hacettepe University Rheumatology Clinic were examined. Forty-four patients who had at least one visit in the last 2 years were included in the analysis. Demographic, clinical and laboratory characteristics of the patients, treatments, clinical and/or ultrasonographically measured lesion sizes at the time of diagnosis and at the last follow-up were recorded. Complete and partial response in the last control visit were defined as $\geq 50\%$ and $<50\%$ decrease in the lesion size, respectively. Lesions which are stable or increasing in size was accepted as unresponsive. Increase in the drug dose by the clinician or increasing of the lesion size during follow-up were considered as relapse.

Results: Median age was 35.7 (24.3–57.2) years and median symptom duration was 2.5 (0.2–54.1) months at baseline. Palpable mass (90.9%) and breast pain (88.1%) were the most common symptoms. Skin fistules and axillary lymphadenopathy were present in 16 (37.2%) and 15 (34.1%) patients, respectively. Erythema nodosum was seen in 5 (11.4%) patients during follow-up. The median follow-up duration was 10.5 (1.05–99.6) months. CS monotherapy and combination of CS and immunosuppressive were used in 3 (7.8%) and 38 (86.4%) patients, respectively. Three patients were followed up without treatment. The first immunosuppressive agent was methotrexate (MTX) in 32 patients (84.2%) and