involvement, and 193 for cutaneous involvement. The group of treatments that most often induces a therapeutic response (in more than 75% of cases) includes lbandronate, Etanercept, Anakinra, Infliximab, Pamidronate and Adalimumab. Pamidronate, which represents the largest subpopulation in our study, has the highest weighted index of efficacy. Zoledronic acid, Leflunomide, Ustekinumab and Methotrexate have less often induced a therapeutic effect (efficacy between 50% and 75%) and Sulfasalazine and Secukinumab have response rates of less than 30%. In total, bisphosphonates and TNF alpha antagonists have efficacy rates of 87.77% and 85% respectively. The weighted index, more than twice as high for bisphosphonates (42.96 versus 17.96), reflects the predominant use of these in SAPHO syndrome, with most often a beneficial effect. Conventional and synthetic targeted DMARDs and other biological treatments are less often effective in our study, with response rates of 47% and 58% respectively. The frequencies of each clinical manifestation were in agreement with the data of the literature. There was no clear clinical profile of a good responder to a particular treatment.

Therapeutic class	Number of patients	Number of responders	Efficacy rate (%)	Weighted index
Bisphosphonates	139	122	87,77	42,96
Conventional	68	32	47,06	11,27
DMARDs				
Synthetic targeted drugs	0	NA	NA	NA
Anti TNF alpha	60	51	85	17,96
Other biologics	17	10	58,82	
TOTAL	284	215	75,82	NA

Conclusions: This work made it possible to rank the different DMARDs used in the SAPHO syndrome. Anti TNF alpha and Pamidronate are the treatments that seem to bring the higher benefit.

Disclosure of Interest: None declared

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SAT0607 DRUGS USED OFF LABEL IN A RHEUMATOLOGY SERVICE OF A TERTIARY HOSPITAL

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Background: The use of drugs off-label (DOL) is not uncommon in Rheumatology daily clinical practice for the treatment of patients with immune-mediated inflammatory diseases (IMID).

Objectives: To analyse the use of DOL requested by the Rheumatology Service.

Methods: We reviewed the medical records of all patients registered in the DOL database of the Hospital Pharmacy Service between July 2009 and March 2017. The following variables were collected: date of approval and start of the drug, physician, disease, reason for indication, sex and age of the patients, response to treatment according to the global assessment of the responsible physician, date and reason of withdrawal. A descriptive study of the variables collected through STATA 12 is carried out.

Results: 225 DOL were requested for a total of 174 patients. Women were 78.7%, with an average age of 56.5 years (sd 1.15). In most patients (77%) a single drug was requested. In 37 patients were requested between two (16.4%) and seven drugs (0.5%). The indications of the DOL in our database were: connective tissue diseases (CTD: 46.6%), vasculitis (23%), rheumatoid arthritis (RA: 5.2%) and spondyloarthritis (SPA:8%). Other diseases (17.2%) are included in two heterogeneous groups classified according to their etiology (autoimmune (8.6%) or not (8.6%).

39.5% of the drugs requested were conventional synthetic DMARDs (csDMARDs), 38.2% biological DMARDs (bDMARDs), 7.5% were antivirals, 2.6% vasodilators and 12% other drugs.

Conventional synthetic DMARDs (csDMARDs) represented 39.5% of request, biological DMARDs (bDMARDs) 38.2%, antiviral drugs 7.5%, vasodilator drugs 2.6% and other drugs 12%.

Tables 1 and 2 show csDMARDs and bDMARDs respectively, according to the indication.

The effectiveness of the DOL was variable, ranging between 0% and 76.5%. The most effective were antiviral drugs, used to treat viral infections in immunosuppressed patients (76.5%), tocilizumab (72.2%) and rituximab (61.1%). By contrast, the least effective were anakinra (0%) and TNF blockers (31.8%). The csDMARDs group had an effectiveness of 53.9% (Mycophenolate stands out with 75% effectiveness).

The disease groups that responded best to DOL therapy were connective tissue and vasculitis, with 58% and 53.7% of effectiveness.

Abstract SAT0607 – Table 1

	RA	CTD	SPA	VASCULITIS	OTHERS ¹
APREMILAST(%)	0	0	50	0	0
CYCLOPHOSPHAMIDE (%)	28.6	1.9	0	0	16.7
CYCLOSPORINE(%)	14.3	7.7	0	4.6	16.7
LEFLUNOMIDE(%)	0	1.9	50	45.5	16.7
MYCOPHENOLATE(%)	42.9	86.5	0	50	50
TACROLIMUS(%)	14.3	1.9	0	0	0

Abstract SAT0607 – Table 2.

	RA	CTD	SPA	VASCULITIS	OTHERS ¹
ABATACEPT (%)	0	0	7.7	3.9	16.7
ANAKINRA(%)	0	0	0	0	25
TNF blockers (%)	0	6	53.9	30.8	41.7
RITUXIMAB(%)	0	87.9	0	26.9	0
TOCILIZUMAB (%)	100	3	23.1	38.5	16.7
USTEKINUMAB (%)	0	0	15.4	0	0

¹Others: other diseases mediated by immune mechanisms

Conclusions: Rheumatic diseases for which DOL is most commonly requested are connective tissue and vasculitis, as a consequence of the absence of specific indications for these pathologies. In our experience, rituximab is a good option in the treatment of connective tissue diseases, which contrasts with the results of some clinical trials. Tocilizumab is a good therapeutic option in the treatment of vasculitis, a group that includes Giant Cell Arteritis, as recently confirmed with its approval for this indication.

Disclosure of Interest: None declared

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SAT0608 HOW TO DIFFERENTIATE ADULT ONSET STILL'S DISEASE FROM OVERALL OTHER CAUSES OF FEVER OF UNKNOWN ORIGIN: RESULTS OF A PROSPECTIVE STUDY FROM A TERTIARY REFERRAL CENTRE

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Background: Adult onset Still's disease (AOSD) is a rare, auto-inflammatory disease that commonly presents as fever of unknown origin (FUO), and most common rheumatologic cause of FUO. Clinical and/or laboratory parameters that can discriminate AOSD from other causes of FUO need to be clarified in current literature.

Objectives: To determine clinical and/or laboratory parameters that help to differentiate AOSD from other causes of FUO and demonstrating a clinician-friendly algorithm for this purpose.

Methods: Data from patients who admitted to Hacettepe University Hospitals, inpatients sections of department of internal medicine with the complaint of FUO, who eventually had a certain diagnosis, collected prospectively during 30 months. AOSD patients followed at Hacettepe University department of rheumatology were included. Clinical and laboratory data were collected at the time of diagnosis of AOSD and time of admission of patients with FUO.

Results: Total 156 patients (n=69, for AOSD; n=87, for FUO) were included. FUO group were also divided into three subgroups: rheumatologic (n=31, 35.6%), infectious (n=28, 32.2%) and malignant (n=28, 32.2%) causes. While 51 (74%) patients were female in AOSD group, 43 (49.4%) patients were female in FUO group (p=0.03). Frequency of rash, arthralgia, arthritis, sore throat, fever at night (p<0.001 for each), history of hemophagocytosis (p=0.037) were significantly higher in AOSD group. Fever peak number equal and/or higher than 3, presence of lymphadenopathy (p=0.002 and p=0.001, respectively) were significantly higher in FUO group. While leukocytosis, neutrophilia, thrombocytosis, hyperferritinemia, higher lactate dehydrogenase and complement 3 levels (p<0.001 for each) were significantly more frequent in AOSD group, albumin levels lower than 3 g/dl and positive rheumatoid factor (p=0.009 and p=0.002, respectively) were significantly more frequent in FUO group. Results of univariate and multivariate analysis are given in table 1. Algorithm for discrimination of AOSD and FUO is given at Abstract SAT0608 – figure 1.

Abstract SAT0608 – Table 1. Results of univariate and multivariate analysis

Variables	Univariate Analysis			Multivariate Analysis		
	Odds Ratio	Confidence Interval	p value	Odds Ratio	Confidence Interval	p value
Favours Still's						
Fever at night	7,66	3,53–16,5	<0001			
Rash	10,08	4,80–21,2	<0001	31,3	3,6–271,9	0002
Arthritis	6,58	3,09–14,01	<0001			
Arthralgia	36	10,46–123,8	<0001	158,1	4,3–5755,8	0006
Sore throat	27,72	11,58–66,33	<0001	20,8	2,8–154,7	0003
Hemophagocytosis	4,79	0,96–23,89	0079			
Neutrophilia	10,87	4,90–24,13	<0001	18,4	2,6–132,3	0004
Ferritin $\geq$ 5 x UNL	4,88	2,34–10,16	<0001	132,8	7,1–2502,9	0001
LDH	7,12	2,35–21,59	<0001	6,2	0,76–50,9	0087
C3	3,20	1,47–7,00	0003			
Female	2,90	1,46–5,73	0002			
Favours FUO						
Pleuritis	2,04	0,68–6,12	0,19			
Fever peak number $\geq$ 3	3,66	1,16–11,52	0019	69	2,2–2114,4	0015
Lymphadenopathy	3,39	1,72–6,79	<0001			

UNL: Upper normal limit (for ferritin: 336 ng/ml)

Conclusions: Presence of arthralgia, hyperferritinemia, sore throat and neutrophilia strongly favour AOSD in patients presenting as FUO. This study demonstrates a clinician-friendly algorithm for the first time in current literature.

Disclosure of Interest: None declared

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SAT0609

VENOUS VESSEL WALL THICKNESS IN LOWER EXTREMITY IS INCREASED IN MALE BEHCET'S DISEASE PATIENTS WITH AND WITHOUT VASCULAR INVOLVEMENT

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Background: Vascular involvement is seen in up to 40% of the patients with Behçet's Disease (BD), especially in young males and is one of the major causes of mortality and morbidity. Lower extremity vein thrombosis due to vascular inflammation is the most frequent form of vascular involvement in BD. Recently, assessment of vessel wall thickness (VWT) and venous dilatation by US is suggested to be valuable in patients with vascular inflammation.

Objectives: In this study, we investigated whether vessel wall thickness or dilatation is present in young male BD patients prone to venous vascular disease.

Methods: Thirty male patients with BD without major organ involvement and 29 male patients with Vascular BD (VBD) followed in Marmara University Behçet's Clinics, 24 healthy male controls and 27 male patients with Ankylosing Spondylitis (AS) were included the study. Bilateral lower extremity venous doppler ultrasonography (US) was performed by an experienced radiologist blinded to cases. No patients except VBD were under immunosuppressive treatment. Bilateral common femoral vein (CFV) wall thickness and great/small saphenous vein dilatations were examined. Behçet Syndrome Activity Score (BSAS) was used for the general assessment of disease activity. In 10 patients, CFV wall thickness was measured by 2 different radiologist (RE, RA) in the same day to calculate "inter-observer reliability". Correlation between radiologists was good. ($r=0.765$, $p<0.001$).

Results: The mean disease duration was 9.1 ± 6 years in patients with BD. BSAS score was 24 ± 17 . All venous measurements were significantly higher in BD compared to AS and healthy controls ($p<0.001$ for all, table 1). When we compared mucocutaneous BD and VBD, all measurements of patients with VBD were higher than mucocutaneous BD. But only left CFV thickness and width of right great saphenous vein reached the statistical significance ($p<0.001$, $p=0.028$, respectively, figure 1). There were no correlations between BSAS, acute phase reactants and venous wall measurements.

Abstract SAT0609 – Table 1. Venous wall measurements of lower extremity in study groups.

	Behçet's Disease (n=59)	Ankylosing Spondylitis (n=27)	Healthy Controls (n=24)	P Value
Age, years	32.5 (23–42)	32 (20–37)	27.5 (25–42)	0.023
Body Mass Index (kg/m ²)	25.1 (18–33)	25 (18–32)	23.8 (20–29)	0.213
Right Common femoral VWT (mm)	0.8 (0.04–1.8)	0.3 (0.1–0.6)	0.25 (0.06–0.4)	<0.001
Left Common femoral VWT (mm)	0.8 (0.3–1.6)	0.3 (0.1–0.5)	0.2 (0.04–0.6)	<0.001
Right Great saphenous width (mm)	3.1 (0–6.4)	2.5 (1.1–3.5)	2.1 (1.3–3.5)	<0.001
Left Great saphenous width (mm)	3.1 (0–7.4)	2.6 (0.3–4.8)	2.4 (1.6–3.6)	<0.001
Right Small saphenous width (mm)	2.8 (0–5.3)	1.7 (1–3.1)	1.4 (0.9–3.7)	<0.001
Left Small saphenous width (mm)	2.7 (0–5.2)	1.8 (1.1–3.4)	1.6 (0.8–3.6)	<0.001

VWT: Venous wall thickness

Abstract SAT0609 – Figure 1. Venous Vessel Assessments of patients with Mucocutaneous Behçet and Vascular Behçet

Conclusions: In our study, an increased venous vessel wall thickness in lower extremity was shown in male BD patients with or without vascular involvement. As a similar change was not observed in controls, we think, increased VWT might be an early sign of venous inflammation in patients with BD rather than a result of non-specific systemic inflammation.

Disclosure of Interest: None declared

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SAT0610

A DECLINING TREND IN FREQUENCY OF SECONDARY AMYLOIDOSIS IN BEHCET'S SYNDROME

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Background: A decline in the frequency of AA amyloidosis secondary to rheumatoid arthritis and infectious diseases has been reported. This is probably due to more effective treatment strategies. We had previously reported that although amyloidosis occurs in less than 0.5% of BS patients, it is one of the leading causes of death.^{1–3} We had an impression that the frequency of amyloidosis is decreasing among our patients with BS.

Objectives: We aimed to determine the change in the frequency of AA amyloidosis over years in BS pts in addition to elaborating on clinical characteristics and outcomes.