Sexual health is rarely addressed by health professionals (HP), and it is as a rule not spontaneously reported by patients. HPs may feel awkward to intrude into the intimate sphere of a patient, and patients may feel ashamed of revealing their sexual dysfunction.

A first step to improve the physician-patient communication in this area is to include sexuality in the curriculum of health professionals teaching how to address and evaluate sexual function. Assessment of sexual function by validated instruments includes both frequency of intercourse as well as sexual desire, arousal, orgasm, and sexual satisfaction. In women vaginal lubrication and in men erectile function and ejaculation are part of the evaluation. Assessment of disease activity and comorbidities helps to detect physical components of sexual dysfunction. Barriers regarding communication on sexual activity should be identified and overcome. Assessment of sexual function may be assigned to a specially trained nurse, an occupational therapist or a psychologist of the interdisciplinary team. Referral to specialists in urology, gynaecology or sexual medicine may also help patients to get a better sex life. A major point for restoring sexual and reproductive health in patients of both genders is to achieve optimal disease control.

REFERENCE:

- [1] Østensen M. Sexual and reproductive health in rheumatic disease. *Nat Rev Rheumatol* 2017;13(8):485–493.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7832

SP0047 CHALLENGES IN THE MANAGEMENT OF DIFFERENT RHEUMATOLOGIC DISORDERS DURING PREGNANCY: LESSONS FROM THE REGISTRIES

R. Fischer-Betz. Rheumatology, Heinrich-Heine-University, Duesseldorf, Germany

Registers have considerably expanded our knowledge in many fields of rheumatology. In particular, the Biologics Registers contribute to an enormous increase in knowledge on the "real world" safety of the rapidly growing treatment options. Family planning in the case of RD is a particular challenge in the physician-patient relationship and requires an optimal strategy. The impact of pregnancy on the underlying disease or the impact of maternal disease on the outcome of pregnancy is not yet fully understood. In addition there is still a high unmet need of data on drug safety as women with wish to have children or pregnant women are excluded from registration studies for ethical reasons. Therefore, systematic and prospective observation in daily care is the best possibility to collect data on this subject. Data options range from clinical-based cohort studies (e.g. the PROM-ISSE study), prospective pregnancy exposure studies (e.g. the MotherToBaby studies) to national birth registries. Recently, pregnancy registers in women with RD have been established in several European countries. Together with other studies, these registers will hopefully add to improved expertise in the future

Disclosure of Interest: R. Fischer-Betz Grant/research support from: GSK, UCB, Consultant for: Medac, UCB, Speakers bureau: Abbvie, Chugai, Janssen, Lilly, UCB, Pfizer

DOI: 10.1136/annrheumdis-2018-eular.7770

THURSDAY, 14 JUNE 2018

Clinical challenges in giant cell arteritis in 2018

SP0048 A CASE OF PULSELESS STROKE

F. Muratore. Rheumatology Unit, Azienda USL-IRCCS di Reggio Emilia, Reggio Emilia, Italy

Giant cell arteritis (GCA) is the most common form of vasculitis in individuals aged 50 years and over. GCA typically affects large and medium-sized arteries, with a predilection for the extracranial branches of the carotid artery. Patients with GCA usually present with symptoms and signs that are directly related to the artery that is affected, with or without constitutional manifestations. The most dreaded complication of GCA is visual loss, which affects about one in six patients and is typically caused by arteritis of the ophthalmic branches of the internal carotid artery. Before the advent of glucocorticoid treatment, the prevalence of visual complications was high. Increasing awareness by physicians of the symptoms of GCA and advances in diagnostic techniques over the past twenty years have also contributed to a substantial decline in the frequency of permanent visual loss. Ischaemic brain lesions are less common than visual lesions, and mostly result from vasculitis of the extradural vertebral or carotid arteries. In the case of both the eye and the brain, ischaemic damage is thought to result from arterial stenosis or occlusion that occurs secondary to the inflammatory process.

A patients with giant cell arteritis with extensive extra and intracranial large vessel involvement effectively treated with cyclophosphamide followed by mycophenolate mofetil will be presented. Diagnosis and management of ischaemic complications in giant cell arteritis will be discussed.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7763

SP0049 HEAD GAMES WITH GCA AND GCS

M. Matza. Rheumatology, Massachusetts General Hospital, Boston, USA

Case 1: This is a 65 y/o woman with osteoporosis, depression and recently diagnosed polymyalgia rheumatica characterised by shoulder and hip girdle pain and stiffness with elevated inflammatory markers. She developed recurrent symptoms and new-onset jaw and tongue claudication in the setting of a prednisone taper. She was found to have a bulging right temporal artery and biopsy confirmed giant cell arteritis. She was placed on prednisone 60 mg daily with resolution of her symptoms, but developed worsening symptoms of depression and anxiety with insomnia on high dose prednisone. She subsequently attempted suicide by intentional medication overdose and carbon monoxide poisoning. She was admitted to the psychiatry ward and additionally found to have a varicella zoster skin rash. Upon resolution of the zoster infection she was started on tocilizumab by subcutaneous injection weekly and prednisone was successfully tapered over 4.5 months without recurrence of symptoms.

Case 2: This is a 63 y/o man with ITP on monthly rituximab and chronic prednisone 10 mg daily, hypertension, hyperlipidemia and osteoarthritis who developed worsening shoulder and neck pain for two months with more recent onset of scalp tenderness and left-sided vision changes for two weeks. He was found to have left optic neuropathy, elevated inflammatory markers, and an MRI demonstrating enhancement of the left temporal artery. Left temporal artery biopsy was normal. He was given pulse dose intravenous methylprednisolone for suspected giant cell arteritis and transitioned to high dose oral prednisone with improvement in musculoskeletal symptoms, inflammatory markers and stabilisation of his vision. He subsequently developed insomnia, hyperactivity and talkativeness and was diagnosed with steroid-induced mania, which improved with antipsychotics and benzodiazepines as per the psychiatry service. He was discharged home and after three days developed new vision loss of the right eye on prednisone 60 mg daily. On exam, he was found to have progressive visual field loss of the left eye and new inferior visual field loss of the right eye with disc oedema of the right optic nerve. Right temporal artery biopsy was negative. He was again given pulse dose intravenous methylprednisolone followed by oral methylprednisolone and ultimately received tocilizumab intravenously prior to discharge.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7655

THURSDAY, 14 JUNE 2018

Do we still need biopsies to diagnose Sjögren's and autoimmune myositis?

SP0050 OPPORTUNITIES AND CHALLENGES OF IMAGING IN PRIMARY SJÖGREN'S

S. Jousse-Joulin. Rheumatology, Cavale Blanche Hospital, Brest, France

Sjogren's syndrome (SS) is a chronic autoimmune inflammatory disorder of exocrine glands. Its diagnosis relies solely on a combination of clinical and laboratory findings. However, recent developments have shown that imaging techniques may have additional value in detecting salivary glands abnormalities in pSS. In general, sialography is considered to be the most reliable of the imaging methods. Salivary gland scintigraphy is very sensitive and especially useful in early stages of the disease. Nevertheless, both imaging techniques are used by only minority of rheumatologists for diagnosis of pSS because of the invasive character of sialography and the low specificity of scintigraphy. MRI has shown a good sensitivity and specificity to detect structural abnormalities in pSS but few centres have access to the specific know-how. A recent development is the increased interest in ultrasonography (US) as a tool to assess major salivary glands. Ultrasonography of the salivary glands (SGUS) appears to be an inexpensive commonly available noninvasive technique that does not cause complications and inconvenience to the patient, although the data are somewhat conflicting. Although, the recent but preliminary American classification criteria for Sjögren syndrome do not include salivary gland such imaging technique¹ this procedure has clearly demonstrated high impact on classification of Sjögren patients²⁻⁵ and demonstrated good diagnostic properties.⁶ A systematic literature review⁶ has shown a paucity of data regarding the metric properties of ultrasound, making interpretation and

comparison of studies difficult. In particular, there are limited data describing a standardised scanning method and standardised definitions of US gland pathologies. Even if we obtained truth validity, discrimination validity (reliability) is not yet validated. Therefore, although SG-US is an upcoming modality in rheumatology, it is not yet ready to make diagnostic or therapeutic decisions regarding salivary glands in daily routine practice. It should still be considered to be a research tool, until we are able to demonstrate acceptable intra- and interobserver reliabilities. Preliminary work addressing these issues has been done so far by the USpSS study group consisting of both clinicians and ultrasonographers.^{6,7}

More recently, a SG-US OMERACT task force group composed of international clinicians and ultrasonographers was created with the aim of developing a standardised scanning method using standardised definitions of gland pathology. A consensual Delphi process about definitions and scoring using B mode modality of SG-US was used and the intra and inter reliabilities between 18 sonographers showed good to excellent reliabilities (Light's kappa=0.81, Light's kappa=0.71 respectively) (article in preparation). Currently, there is an unmet need concerning the use of SGUS in the monitoring of patients. Even if it seems that structural damage are stable over time.⁸ Another possible way to study SG in the disease course is to use Doppler. Doppler waveform analysis was found useful for detecting blood flow abnormalities in SG of patients with pSS compared to controls.⁹ Given the importance of parotid and submandibular glands involvement in pSS, we believe that the vascularisation and B mode sonography should be evaluated routinely. A new US technique measuring the elasticity of SG parenchyma using elastography has recently emerged and could be implemented in the evaluation of SGUS pSS patients.¹⁰⁻¹² Some authors showed that stiffness of SG parenchyma was increased compared to healthy controls and suggested to adjunct this procedure to gray-scale ultrasonography for the clinical diagnosis of pSS. The last important challenge is to know if imaging techniques are capable to replace minor salivary glands biopsy. A recent study¹³ has shown good agreement between SGUS and parotid gland and moderate with labial glands.

In conclusion, US has nearly completed the 3 pillars of the OMERACT process (truth validity, discrimination validity and feasibility). The use of different imaging technique and particularly ultrasonography should be educated and it is now of importance to train the rheumatologists to this technique as proposed by The US EULAR courses.

REFERENCES:

- [1] Shiboski CH, et al. *ARD* 2017.
- [2] De Vita S, et al. *Clin Exp Rheumatol* 1992.
- [3] Goules AV, et al. *Nat Rev Rheumatol* 2014.
- [4] Obinata K, et al. 2010.
- [5] Wernicke D, et al. *J Rheumatol* 2008.
- [6] Jousse-Joulin S, et al. 2016.
- [7] Vitali C, et al. *Arthritis Rheum* 2013.
- [8] Gazeau P, et al. *Joint Bone Spine* 2018.
- [9] Jousse-Joulin S, et al. *Biologics* 2007.
- [10] Hofauer B, et al. *Ultrasound Med Biol* 2016.
- [11] Zhang S, et al. *Ultrasound Med Biol* 2016.
- [12] DeJaco C, et al. *Ultrasound Med Biol* 2014.
- [13] Mossel E, et al. *ARD* 2017.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7827

THURSDAY, 14 JUNE 2018

How monogenetic autoinflammatory diseases help to understand and treat rheumatic diseases

SP0051 CLINICAL PRESENTATION OF AUTOINFLAMMATORY DISEASES IN CHILDREN AND ADULTS: HOW NOT TO MISS THESE PATIENTS

S. Ozen. *Pediatric Rheumatology, Hacettepe University, Ankara, Ankara, Turkey*

Autoinflammatory diseases are diseases of the innate immune system, characterised by attacks of inflammation. The inflammatory attacks can manifest in a variety of forms; fever, is frequent, the skin and musculoskeletal system is often affected. Acute phase reactants are increased in almost all of the patients. The autoinflammatory diseases can be classified according to their leading manifestations such as: those with periodic fevers (and other various features), those with pyogenic

features, those with psoriasis, those with features of interferopathies and those with vasculopathy. With this large range of features these diseases are in the differential of many common diseases. Genetic testing is confirmatory but may not be widely available.

The differentiating features of especially the common autoinflammatory diseases will be reviewed.

Disclosure of Interest: S. Ozen Consultant for: Novartis, Speakers bureau: SOBI

DOI: 10.1136/annrheumdis-2018-eular.7861

THURSDAY, 14 JUNE 2018

Joint EULAR – EFIS session: I've got a B in my bonnet

SP0052 POSTTRANSLATIONAL MODIFICATION OF AUTOANTIBODIES IN RA

L. Trouw^{1,2}. ¹*Immunohematology*; ²*Rheumatology, LUMC, Leiden, Netherlands*

Rheumatoid Arthritis (RA) is a common autoimmune disease in which autoantibodies serve as interesting biomarkers. In a large proportion of the patients several types of autoantibodies are present that target post-translationally modified proteins. Next to antibody responses against citrullinated proteins (ACPA) we now also describe antibody responses against carbamylated proteins (anti-CarP) in RA. The use of these autoantibodies in the prediction, diagnosis and prognosis will be discussed, as well as the clues, obtained in animal models, as to how such an antibody response may be initiated.

In addition the findings that antibodies themselves are also post-translationally modified and the functional consequences of such modifications will be highlighted both regarding carbamylation of IgG and modifications of ACPA IgG.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7810

SP0053 MEMORY PLASMA CELLS IN CHRONIC INFLAMMATORY DISEASES – A ROADBLOCK TO TOLERANCE INDUCTION

^{1,2}A. Radbruch. ¹*Charité University Medicine*; ²*Deutsches Rheumaforschungszentrum Berlin, a Leibniz Institute, Berlin, Germany*

Regeneration of tolerance is the Holy Grail of treating inflammatory rheumatic diseases. Obviously neither physiological nor therapeutic immunosuppression does achieve this for most patients. What are the roadblocks for therapies inducing therapy-free remission? We have identified memory plasma cells secreting pathogenic (auto)antibodies as one such roadblock. Such cells are often generated already before disease becomes clinically apparent. They persist over time in inflamed tissues and in the bone marrow, in niches which protect them from environmental stress, including conventional therapies. By constitutive secretion of pathogenic antibodies they fuel relapse and refractoriness. Any therapy aiming at induction of therapy-free remission will have to remove this roadblock. Recently we and others have developed therapeutic concepts to ablate memory plasma cells, based on a molecular understanding of their lifestyle. Such therapies, however, have two major inherent problems:¹ they also ablate protective humoral immunity, increasing risk of infection, and ² the pathogenic memory plasma cells can be regenerated, if tolerance is not regenerated. To address the latter point, ablation of plasma cells has to be combined with tolerance-inducing therapeutic options, and until then, patients have to be protected passively by IV-Ig. For selective targeting of pathogenic memory plasma cells, differences in the lifestyle between protective and pathogenic plasma cells could be exploited, but few have been identified so far. We have now developed a novel technology to target plasma cells according to the specificity of the antibodies they secrete. Plasma cells are labelled *in vivo* with a given antigen, and those plasma cells secreting specific antibodies are selectively killed by their own antibodies. We have now demonstrated feasibility and efficacy of this therapeutic approach in a preclinical model. Apart from the therapeutic perspective, this technology also offers a unique option to identify pathogenic plasma cell specificities in experimental and clinical rheumatology.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7758