ALTERTIVE CHARACTERS AND OUTCOMES OF CLINICAL OUTCOMES AND RESPONSE TO ANTI-TUMOUR NECROSIS FACTOR MEDICATIONS (ANTI-TNFs) ARE EFFECTIVE IN CONTROLLING CHRONIC INFLAMMATORY DISEASES, BUT INFORMATION ABOUT THEIR USE AND OUTCOMES OF PREGNANCY IS LACKING.

**Background:** Anti-tumour necrosis factor medications (anti-TNFs) are effective in managing chronic inflammatory diseases, but information about their use and outcomes of pregnancy is lacking.

**Objectives:**
- This study was funded by UCB Pharma.
- The authors thank the patients and their caregivers in addition to the investigators and their teams who contributed to this study.
- Editorial services were provided by Costello Medical.

**Disclosure of Interest:**
- All costs associated with this abstract were funded by UCB Pharma.

**Methods:**
- This study was funded by UCB Pharma.

**Conclusions:**
- The authors thank the patients and their caregivers in addition to the investigators and their teams who contributed to this study.
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**References:**
- Pfizer, Roche, UCBLilly, M. de Hooge.
- Employee of: UCB Pharma, Pfizer, Roche, Merck.
- Consultant for: Pfizer, Roche, Merck.
- Employee of: UCB Pharma, Pfizer, Roche, Merck.
- M. Cooney.
- L. Shaughnessy.
- M. Vanderkelen.
- F. Förger.

**Figure 1**
- Overview of pregnancy reports.

**Table 1**
- TMA lesions were classified into acute and chronic.
- Renal biopsies were performed in all patients.
- Antibody profiles, induction therapy, and maintenance therapies for LN, and anti-thrombotic treatments were collected.

**Abstract OP0200**
- Figure 1 Overview of pregnancy reports.

**DOI:** 10.1136/annrheumdis-2018-eular.1114

**THURSDAY, 14 JUNE 2018**

**Reproductive issues in rheumatology**

**OP0200**

**CHARACTERISTICS AND OUTCOMES OF PROSPECTIVELY REPORTED PREGNANCIES EXPOSED TO CERTOLIZUMAB PEGOL FROM A SAFETY DATABASE**


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**Background:** Anti-tumour necrosis factor medications (anti-TNFs) are effective in controlling chronic inflammatory diseases, but information about their use and safety in pregnancy is limited. Consequently, anti-TNFs are often discontinued early in gestation. Certolizumab pegol (CZP), an Fc-free, PEGylated anti-TNF, has no proven benefit in controlling chronic inflammatory diseases, but information about their use and outcomes of pregnancy is lacking.

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**Abstract OP0200**
- Figure 1 Overview of pregnancy reports.

**DOI:** 10.1136/annrheumdis-2018-eular.2417

**THURSDAY, 14 JUNE 2018**

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

**OP0201**

**CLINICAL OUTCOMES AND RESPONSE TO ANTI-THROMBOTIC TREATMENT AMONG PATIENTS WITH CONCOMITANT LUPUS NEPHRITIS AND THROMBOTIC MICROANGIOPATHY: A MULTICENTER COHORT STUDY**


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**Background:** In addition to glomerular lesions, renal vascular involvement is an important prognostic marker of lupus nephritis (LN). Among patients with various vascular changes, individuals with thrombotic microangiopathy (TMA) present with severe clinical manifestations and have a high mortality.

**Objectives:**
- We sought to assess renalal outcomes and response to anti-thrombotic treatments in addition to conventional immunosuppression in patients with biopsy proven LN and TMA.

**Methods:**
- Clinical and renal histopathological data for 97 patients with biopsy-proven LN and TMA were retrospectively analysed. Antibody profiles, induction and maintenance therapies for LN, and anti-thrombotic treatments were collected. TMA lesions were classified into acute and chronic (table 1). A complete renal response (CR) was defined as proteinuria <0.5 g/24 hour and normal or near-
normal (within 10% of normal GFR if previously abnormal) GFR. Partial Response (PR) was defined as ≥50% reduction in proteinuria to subnephrotic levels and normal or near-normal GFR. Renal outcomes were assessed at one year post-biopsy. **Results:** The mean age of the patients was 38.9±15.2 years (range, 13–69 years). The study included 85 females (87.6%) and 12 males (12.4%). The clinical presentations were nephrotic syndrome, nephritic syndrome, and asymptomatic urinary abnormalities (38 (39.2%), 20 (20.6%), 39 (40.2%) patients, respectively. Nine patients were classified Class III (9.3%, including 2 as Class III-V1), 82 as Class IV (84.5%), 10 as Class IV-segmental (IV-S) (10.3%) and 72 as Class IV-global (IV-G) (74.2%), including 4 as Class IV-G+V and 6 as Class V (6.2%). Forty-two (43%) patients presented with acute and 55 (57%) with features of chronic TMA. All patients had received treatment with standard immunosuppressants (55% mycophenolate, 39% cyclophosphamide, 6% other regimens) and steroids.

Abstract OP0201 – Table 1

<table>
<thead>
<tr>
<th>Feature</th>
<th>Acute TMA Features</th>
<th>Chronic TMA Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Endothelial swelling with partial or complete occlusion of lumina;</td>
<td>• Capillary wall thickening with double contours;</td>
<td></td>
</tr>
<tr>
<td>• Microthrombi, focal or global;</td>
<td>• Organizing capillary thrombi;</td>
<td></td>
</tr>
<tr>
<td>• Fragmented RBC on glomerular subendothelial space and/or mesangial areas;</td>
<td>• Glomerular ischemic collapse with arteriolar occlusion;</td>
<td></td>
</tr>
<tr>
<td>• Segmental/glomerular collapse;</td>
<td>• Global/glomerular collapse;</td>
<td></td>
</tr>
<tr>
<td>• Glomerular congestion with effluent arteriole occlusion;</td>
<td>• Arteriolar occlusion;</td>
<td></td>
</tr>
</tbody>
</table>

At 12 months, CR was observed in 37 patients (38.1%), PR in 22 (22.6%) and no response in 38 (39.1%). Sixty-one patients (62.9%) were antiphospholipid positive (aPL) and 37 (38.1%) received anticoagulation with vitamin-K antagonist (VKA) and/or heparins. Presence of aPLs (OR, 2.4; 95% confidence interval 1.2–7.3; p=0.03), anti-DNA positivity (OR, 12.8; 95% CI: 3.0 to 71.3; p=0.002), and chronic features of TMA (OR, 3.0; 95% CI: 1.2 to 7.5; p=0.04) were all found to be associated with no response. When limiting the analysis to aPL positive patients, after adjusting for type of immunosuppressant therapy and LN class on biopsy, variables that were significantly associated with CR were features of acute TMA rather than chronic (OR, 6.82; 95% CI: 1.4 to 79.1; p=0.03) and the use of VKA/heparins (OR, 2.1; 95% CI: 1.02–16.2; p=0.046).

**Conclusions:** Patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes. In patients with concomitant LN and TMA, the presence of aPL and chronic features of TMA were associated with poorer renal outcomes.

**Disclosure of Interest:** None declared


**OP0202** GENE EXPRESSION PROFILES IN PRIMARY SJOGREN’S SYNDROME WITH AND WITHOUT SYSTEMIC MANIFESTATIONS

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**Background:** Different phenotypes characterise the clinical spectrum of primary Sjögren’s syndrome (SJS). Patients with a clinical expression limited to glandular features (GFs) are classically distinguished from patients with extra-glandular manifestations (EGMs). The former patients often complain higher level of fatigue and widespread pain (WP). (Segal et al. 2013) This suggests that gene expression pattern may be different in the two subgroups.

**Objectives:** To investigate the differences of gene expression in SJS patients with GFs and in those with EGMs.

**Methods:** Nineteen patients with SJS were selected for the study. Gene expression in peripheral blood mononuclear cells (PBMCs) was analysed in 4 patients with EGMs and 4 patients with GFs alone using Clarion D human Affymetrix gene chip (Affymetrix, Santa Clara, CA, USA), and compared to that found in healthy controls. Differences in gene expression were evaluated by analysis of variance (ANOVA) and Step-Up FDR-controlling procedure, being FDR corrected p-values<0.01 and fold change >2 considered as statistically significant.

**Results:** Gene expression was performed by quantitative Real Time (qRT)-PCR in PBMCs from all the selected SJS patients, using the ∆∆Ct method for comparing relative fold expression differences.

**Conclusions:** These data indicate that in SJS patients with GFs alone a dysregulation of pain pathways (namely beta-adrenergic receptor and Notch signalling) may play a role in the development of WP that is common in this subset of patients. The biological mechanisms triggering the activation of these genes remain to be completely clarified.

**Disclosure of Interest:** None declared


**OP0203** SAFETY AND EFFICACY OF INTRAVENOUS ADMINISTRATION OF BONE-MARROW DERIVED MESENCHYMAL STEM CELLS IN THERAPY REFRACTORY JUVENILE IDIOPATHIC ARTHRITIS PATIENTS, A PHASE IIb/IIA PILOT-STUDY

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**Objective:** To compare the total number of adverse events (AEs)’s before and after mesenchymal stromal cell (MSC) infusion in refractory JIA and to evaluate its effectiveness.

**Methods:** Single-centre Phase IIb/IIa, open label intervention study in JIA patients previously failing all biologicals registered for their diagnosis. Six patients will receive 2 million/kg intravenous infusions of allogeneic bone-marrow derived MSC. In case of ACR-Ped30-response but subsequent loss of response one and maximal two repeated infusions are considered as statistically significant.

**Results:** Six JIA patients with 9.2 years median disease duration, still active arthritis and damage were included. All had failed methotrexate, corticosteroids and median 5 different biologicals. MSC were administered twice in 3 patients. No acute infusion reactions were observed and a lower post-treatment than pre-treatment incidence in AE’s was found. The one sJIA patient had again an evolving macrophage activation syndrome, 9 weeks after tocilizumab discontinuation and 7 weeks post-MSC infusion. Eight weeks after one MSC infusion, 4 patients showed less active joints, 5 patients improved in many clinical parameters and inflammatory parameters decreased in 3/4. After 1 year, we found significantly lower active joint counts.

**Disclosure of Interest:** None declared


**THURSDAY, 14 JUNE 2018**

How monogenetic autoinflammatory diseases help to understand and treat rheumatic diseases

**OP0203** SAFETY AND EFFICACY OF INTRAVENOUS ADMINISTRATION OF BONE-MARROW DERIVED MESENCHYMAL STEM CELLS IN THERAPY REFRACTORY JUVENILE IDIOPATHIC ARTHRITIS PATIENTS, A PHASE IIb/IIA PILOT-STUDY