Abstract AB1084 – Table 1

	Calprotectin (µg/mL) (range)	PCR (mg/dL) (range)	ESR (mmHg) (range)
Active	3,43 ^{1.80} – 5.31	4,27 (0,7–11,6)	16,86 ^{3–51}
Inactive	2,15 (0,78–4,06)	1,83 (0,7–4,6)	13,11 ^{3–43}

Calprotectin was statistically correlated with Clinical Activity ($p=0.018$), however, neither ESR ($p=0.539$) nor RCP ($p=0.059$) did, although in RCP there was a clinical trend, (ANOVA)

Calprotectin, RCP and ESR were negative in 91%, 80% and 76% respectively of Inactive patients; and positive in 43%, 100% and 33% of the Active ones

The analysis of the ROC curves in our sample showed that the value that allows to discriminate between active and non-active disease with a Sensitivity of 80% and a Specificity of 69% is 2'07 µg/mL

Serum Calprotectin was 2 points higher in the group of patients with Autoinflammatory diseases than in the group of JIA, with a mean of 4.91 compared to 2.90 ($p=0.002$). However, since it is a retrospective study, we must bear in mind that this can be influenced by the reasons for the test request, being in the group of Autoinflammatory Disease the suspicion of active disease, and in the AIJ simply monitoring or assessment of treatment optimisation.

It should be noted that, in the patients in diagnostic process that did not present any rheumatological disease (final diagnoses of: arthralgias in 3 cases and glomerulonephritis not associated to rheumatologic/autoimmune disease in 1), serum Calprotectin did not exceed in any case the 1.15 µg/mL

Conclusions: Serum Calprotectin is emerging as a useful marker, not only in the field of JIA, but also in other diagnostic groups such as Autoinflammatory Diseases.

Prospective and larger studies are needed to determine its role

Disclosure of Interest: None declared

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AB1085 THE FACTORS AFFECTING REMISSION IN JIA PATIENTS, SINGLE CENTRE RESULTS

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Background: Juvenile idiopathic arthritis (JIA) is the most common rheumatic disease in childhood. Nowadays, in the management of JIA, clinical remission is the accepted goal. However, remission is much associated with the JIA subtype and inversely with suggested predictors for poor outcome.

Objectives: The aim of the study is to evaluate the predictors of clinical outcome in patients with juvenile idiopathic arthritis

Methods: This was a single-centre, an observational study including children diagnosed with JIA at Health Sciences University Istanbul, Umraniye Education and Research Hospital, Turkey, between June 2016 and January 2018. All patients were evaluated at the time of diagnosis, and at 3 months of their disease. We routinely collected the patients' baseline profile which included the age of disease onset, gender, number of active joints, patients'and physicians'global assessment of disease activity (PGA, range from 0 to 10 mm; 0 is the best score), the JADAS 27 score. and therapy. Patients were identified through the divisional database which includes all patients seen in the rheumatology clinic.

Results: A total of 141 JIA patients were included in the analysis. The mean follow-up duration of these patients was 23.36 months (range from 12 to 156 months). We examined 71 joints in all patients. At the time of diagnosis, it was seen that they were frequently in knee joint (61.7%) and sacroiliac joints (34.8%). The rate of improvement of joints in the last visit was found to be metatarsophalangeal joints (100%), sacroiliac joints (79%) and knee joints (44.8%), respectively. The non-systemic group (n=133) was evaluated for initial steroid use, among the patients, 54 (% 41) had steroid therapy at the time of diagnosis. There was seen that 29 of the 141 patients (20.6%) were in the remission in 3 months of follow-up. According to subtype of JIA patients, systemic patients (62.5%) were frequently in remission at 3 months. At the end of the study, of the 141 patients, 72 (51.1%) achieved remission and were assigned to the remission group. Among the patients in the remission group, 44 (49.4%) had episodes of disease flares. The other 30 (40.5%) patients did not have disease flares. Comparing the baseline

data in the remission group and non-remission group, there was no difference between these two groups in disease onset age, gender, JIA subtypes, number of active joints at disease onset and JADAS 27 scores and used steroid therapy.

We also analysed whether each group used biological drugs and analysed the duration of starting biologic therapy. Among 72 patients achieved remission, 17 (23.6%) patients had at least one biological drug. There was no difference between two groups. The median time of biologic drug starting was 12 (interquartile range (IQR), 12) months. There was longer time of biologic drug starting in non-remission group than remission group (32.3 ± 36.2 vs 25.0 ± 31.4 , $p>0.05$). We determine that in systemic and poli JIA patients who were used biological therapy were found to have a high percentage of achieved to remission

Conclusions: JIA is a heterogeneous disease with significant variability in course and long-term outcome. No parameter could be used as a single predictor of long-term outcomes. Standardised baseline work-up, disease activity evaluation and a definition of a treat to target approach will result in better health outcomes for JIA patients

Disclosure of Interest: None declared

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AB1086 A 6-MONTH, MULTICENTER, OPEN-LABEL, EXPLORATORY STUDY OF FIXED DOSE NAPROXEN/ESOMEPRAZOLE IN ADOLESCENT PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS (JIA)

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Background: JIA is an inflammatory arthritis of unknown etiology, which lasts for greater than 6 weeks with onset before 16 years of age.^{1 2} Per the ACR guidelines, JIA is the most common chronic rheumatic disease in children.³ NSAIDs have been the mainstay of initial management with naproxen being commonly used, but they can cause serious side effects such as gastritis. Herein, we report the results of a clinical trial in JIA patients receiving one of 3 fixed doses of naproxen/esomeprazole magnesium (nap/eso) given BID (table 1).

Objectives: To evaluate the signs/symptoms of JIA, safety and tolerability of nap/eso in adolescents age 12 to 16 years.

Methods: Forty-six children and adolescents with JIA by ILAR criteria, mean age of 13.6 years, from 18 US sites were prospectively enrolled over 2 years and treated for up to 6 months. Mean number of active joints at baseline was 3.1. Doses were based on baseline weight (table 1). Disease activity was assessed with the ACR Pediatric-30, -50, -70, -90 Response and the Childhood Health Assessment Questionnaire (CHAQ) discomfort and functional scores at months 1, 3, and 6 as change from baseline. Occurrence and causality were assessed for treatment emergent AEs (TEAEs) and discontinuations were monitored monthly.

Results: Forty-six patients received at least 1 dose of study drug and 36 completed the trial. The% of patients achieving ACR Paediatric response increased over time (figure 1). CHAQ discomfort improved at each assessment and functional scores improved at all assessments for 'Arising, Walking, and Activities' with several improved for 'Dressing and Grooming, Eating, Hygiene, and Grip'. There was no indication of a dose-related efficacy effect. Thirty-seven (80.4%) had at least 1 TEAE. Frequent TEAEs ($\geq 5\%$) were upper respiratory tract infection, upper abdominal pain, sinusitis, diarrhoea, headache, nausea, and ligament sprain. Eleven (23.9%) had at least 1 TEAE considered to be related to study drug. Most frequent study drug-related TEAE ($\geq 5\%$) was upper abdominal pain. Four (8.7%) discontinued due to a TEAE.

Abstract AB1086 – Table 1. Minimum and Maximum Study Drug Dose (nap/eso) by Weight Group

Weight at Enrollment (kg) ¹	Minimum Dose ²	Maximum dose ²
<38	250 mg/20 mg	250 mg/20 mg
38 –<50	250 mg/20 mg	375 mg/20 mg
50 –<75	375 mg/20 mg	500 mg/20 mg
≥ 75	500 mg/20 mg	500 mg/20 mg

¹ Based on typical day-to-day fluctuations in body weight, at $\pm 3\%$ window was permitted and used at the discretion of the Investigator when assigning the initial dose group. ² Study drug dose, given twice daily.