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 Incactive 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 AJU simply monitoring or assessment of treatment optimisation.

It should be noted that the patients in diagnostic process that did not present any rheumatological disease (final diagnoses of: arthralgia in 3 cases and glocernalonaphritis not associated to rheumatologic/autoimmune disease in 1), serum Calprotectine 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


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 physician's 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. We examined 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±5.6 vs 25.0±3.14, p<0.05). We determine that in systemic and poly 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

Note: the number above each bar represents the number of patients at that dose. The ACR Pediatric-30,–50, –70, and –90 responses were defined as an improvement of at least 30% (or 50%, 70%, 90% respectively) from baseline in at least 3 of the 6 signs and symptoms variables, with no more than 1 of the remaining variables worsening by >30%. JIA signs and symptoms variables: physician’s global assessment of disease activity, CHAQ disability index score, CHAQ global assessment of well-being, number of joints with active arthritis, number of joints with limited range of motion, serum CRP or ESR.

Conclusions: Improvement in JIA signs and symptoms occurred at most assessments and by month 6, the percentage of patients with an ACR Pediatric-30,–50, –70, and –90 Response was 47.1%, 38.2%, 32.4%, and 17.6%. No new safety signals were identified for the well-characterised components of this fixed dosed JIA treatment, which was developed to reduce the risk of gastric ulcers.

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AB1087 PROLONGED RESPONSE WITH TUMOUR NECROSIS FACTOR ALFA INHIBITION IN A 5 YEAR OLD BOY WITH SEVERE MANIFESTATIONS OF IL-36 RECEPTOR ANTAGONIST DEFICIENCY (DITRA)

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Background: Deficiency of the interleukin (IL)–36 receptor antagonist (DITRA).

Methods: A five-year-old came to our dermatology clinic after worsening of a previous diagnosed plaque psoriasis, with an erythematous scaly dermatitis that extended throughout the trunk. Treatment with acitretin and cyclosporin were not effective and patient developed in few weeks a generalised erythroderma with pustules covering almost every part of his body, including palms and soles. He was admitted for the onset of fever and irritability due to painful rubbing of the skin. Family history of recurrent fevers or psoriasis were not revealed. Parents were not consanguineous. Complete blood count showed leukocytosis with neutrophilia and thrombocytosis, with an erythrocyte sedimentation rate (ESR) of 6 mm/hr and a C-reactive protein (CRP) of 8.4 mg/dl. Biochemistry panel revealed a mild elevation of liver enzymes without other abnormalities. Antinuclear antibody (ANA) and rheumatoid factor were negative with normal serum immunoglobulin and complement. Blood culture grew E. Coli, S. Maltophila and S. epidermidis. Skin biopsy showed acanthosis and papillomatosis with perivascular polymorphous inflammatory cells. Genetic analyses showed a homozygous mutation in the IL36RN gene (pSer113Leu). No mutations were detected in IL1RN and CARD 14 genes.

Results: Treatment was initiated with intravenous methylprednisolone 2 mg/kg/ day and subcutaneous anakinra 2 mg/kg/day. Cefotaxime and co-trimoxazole were added until blood cultures were negative. Although skin lesions improved during the following days and patient was finally discharged, symptoms reappeared when decreasing the steroid dose. Three months later adalimumab and methotrexate were started, allowing the patient to end treatment with corticoids without evidence of activity of the disease.

Disclosure of Interest: None declared


AB1088 CAPILLARY HEMOSIDERIN DEPOSITS OR EXTRAVASATIONS: A SUBTYPE OF HAEMORRHAGETHAT ACQUIRES SEPARATE ATTENTION IN QUANTITATIVE ANALYSIS OF NAILFOLD CAPILLAROSCOPY IN CHILDHOOD-ONSET SLE

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Background: Quality of images in nailfold capillaroscopy has improved in the last years by introduction of videocapillaroscopy. Microangiopathy, as observed in capillaroscopy of SLE-patients,1 can now be described by more detailed quantitative analysis. Recently, in a small cohort (n=22) of childhood-onset SLE (cSLE), we described capillary bleedings by two different subtypes: large haemorrhages and small point-shaped haemorrhages with a total count of resp. 0.2/1.5 per...