analysed image per patient. These small point shaped haemorrhages have also been described as hemosiderin deposits.  

Methods: Three observers, DS (paediatric rheumatologist with experience in capillaroscopy), AN (fellow paediatric rheumatologist without experience in capillaroscopy) and MB (trainee in adult rheumatology with experience in capillaroscopy), scored capillaroscopy images from patients with Raynaud’s phenomenon and with cSLE. The observers were blinded for patient name and diagnosis. The number of haemorrhages were scored per subtype. Hemosiderin deposits were defined as small point-shaped extravasations surrounding the capillary apex (see image). Large haemorrhages were defined according to the Atlas of Capillaroscopy. Reliability was calculated by the intra-class correlation coefficient (ICC) with 95% confidence interval (CI). Statistical analyses was performed by IBM SPSS Statistics version 24.

Results: Two-hundred images from 50 patients (diagnosed with Raynaud’s phenomenon and/or cSLE) were scored by the three independent observers. ICC for the number of capillaries with hemosiderin deposits was 0.77 (95% CI 0.69–0.82). ICC for the number of large capillary haemorrhages was 0.97 (95% CI 0.96–0.98).

Conclusions: Reliability of the observation ‘hemosiderin deposits’ in nailfold videocapillaroscopy was good with an ICC of 0.77. This study shows that capillary haemorrhages can be described in 2 subtypes: 'large haemorrhages' and 'hemosiderin deposits' which are small point-shaped extravasations surrounding the capillary apex.

REFERENCES:

Disclosure of Interest: None declared

Abstract AB1089 – Figure 1

INVESTIGATION OF THE EFFICACY AND SAFETY OF SECUKINUMAB TREATMENT IN JUVENILE IDIOPATHIC ARTHRITIS SUBTYPES OF JUVENILE PSORIATIC AND ENTHESIS-RELATED ARTHRITIS: DESIGN OF A RANDOMISED, DOUBLE-BLIND, PLACEBO CONTROLLED, MULTICENTER STUDY

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Background: Secukinumab (AIN457), a fully human anti-interleukin-17A monoclonal antibody, has demonstrated a significant clinically meaningful efficacy on signs and symptoms, structure and function in adults with ankylosing spondylitis (AS)1 and psoriatic arthritis (PsA)2, both approved indications. These data support the proposed study in children with enthesitis-related arthritis (ERA) and juvenile psoriatic arthritis (JPsA).

Objectives: This phase 3 study will investigate the efficacy and safety of secukinumab in children≥2 to 18 years with active JPsA or ERA. The primary objective is to demonstrate that the time to flare in a double-blind placebo control treatment withdrawal part of the trial is longer with secukinumab than placebo.

Methods: Eighty biologic-naive children with active ERA or JPsA (active: ≥3 active joints and/or ≥1 site of enthesis at baseline or documented by history) will enter into treatment period 1 and receive weekly open label s.c. secukinumab 75 or 150 mg, based on their body weight (≥50 kg or ≥50 kg) to maintain secukinumab blood levels equivalent to the adult 150 mg dose, for the first month then for 4 weeks thereafter. At week 12, responders (minimum JIA ACR Pedi 30 response) enter treatment period 2 and will be randomised to receive secukinumab or a matching placebo every 4 weeks. Patients enter treatment period 3 if they experience a disease flare or when the treatment period 2 closes for the entire study because the target number of flares has been reached. Upon entering treatment period 3, patients receive open-label secukinumab every 4 weeks until week 100 and then followed until week 112.

Results: The primary efficacy endpoint will be time to flare in treatment period 2. Key secondary endpoints include JIA Pedi ACR 30/50/70/90/100 response rate, total dactylitis and enthesis counts at week 12. Safety and tolerability will be assessed throughout the study.

Conclusions: The efficacy of Secukinumab in the approved adult indications of PsA and AS support the current study design to evaluate the efficacy and safety of secukinumab treatment in children with active JPsA or ERA. The primary efficacy endpoint will be time to flare in treatment period 2. Key secondary endpoints include JIA Pedi ACR 30/50/70/90/100 response rate, total dactylitis and enthesis counts at week 12. Safety and tolerability will be assessed throughout the study.

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AB1090

ANALYSIS OF A COHORT OF PATIENTS ATTENDING A COMBINED OPHTHALMOLOGY- RHEUMATOLOGY CLINIC IN A TERTIARY REFERRAL CENTRE EGYPT

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Background: Paediatric rheumatologic diseases may have sight-threatening ocular complications including uveitis, scleritis, and retinopathy. Conversely, children presenting with uveitis, scleritis, episcleritis, or optic neuritis may have an underlying rheumatologic disease. Combined ophthalmology-rheumatology clinics can facilitate the comprehensive management of these patients.

Objectives: To describe the demographic characteristics, paediatric rheumatologic diseases distribution, paediatric ocular manifestations distribution, and active treatments in a combined ophthalmology-rheumatology clinic in a tertiary referral centre in Egypt.
Methods: We included all new patients who attended a combined ophthalmology–rheumatology clinic at a tertiary referral hospital from the 1st of October 2015 to the 30th of November 2017. We analysed their demographic, clinical, laboratory, and treatment characteristics. Patients were considered to have activity according to the joint opinion of the ophthalmic and rheumatologic consultants.

Results: We included 538 new patients. 331 were female (61.5%) and the median age (range) was 8.1 years (1.1–17.3). 59.5% of the patients had juvenile idiopathic arthritis (JIA), whereas patients with SLE, Behçet’s disease, dermatomyositis, scleroderma, and juvenile ankylosing spondylitis represented 8.6%, 8.1%, 7.2%, 4.7%, and 4.3% of the studied cohort respectively. At the end of the study period, 72.3% of the patients with Behçet’s disease had uveitis, of which 34.6% suffered profound diminution of vision in the affected eye(s) despite receiving anti TNFs. Other medications that were given were prednisolone, azathioprine, cyclosporine, and cyclophosphamide.

REFERENCES:

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AB1091 TOLERABILITY OF VACCINATION OF 13 PCV IN PATIENTS WITH JIA, WITHOUT SYSTEMIC MANIFESTATIONS

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Background: Juvenile idiopathic arthritis (JIA) is one of the most frequent and most disabling rheumatic diseases in children. Children with JIA receiving immunosuppressive and genetically engineered biologic drugs belong to the high-risk group for the development of bacterial and viral infections, including those administered by preventive vaccines.

Objectives: Our aim was to evaluate the tolerability of the pneumococcal 13-valent conjugate vaccine (PCV) in children with JIA.

Methods: In a prospective cohort study, 3 groups were formed: children with JIA in the remission phase on methotrexate or etanercept (group I), with JIA in the active phase prior to the appointment of methotrexate or etanercept (group II), control group (conditionally healthy children). 0.5 ml of the 13-valent PCV was administered once subcutaneously during therapy in patients in the remission phase or 3 weeks before the appointment of methotrexate or etanercept in patients in the active phase.

Results: At this stage of work, the tolerability of the 13 PCV vaccine was evaluated in patients with JIA, without systemic manifestations. In our study, the post-vaccination period was asymptomatic in 58% of the children in Group I, 66% in children in Group II, and in 60% in the control group. Most often in the postvaccinal period, local reactions were noted, which were painful at the place of administration of the vaccine in 6% of the children in group I, 8% in group II, and 24% in the control group, respectively. Less developed oedema and hyperemia at the injection site – in 12% of children in group I, 6% in group II, in 8% of children in the control group. There was no significant difference in the incidence of local reactions to vaccination of 13 PKV in patients with JIA and in children of the control group. Analysis of the time of occurrence and duration of local and systemic reactions to vaccination of 13 PKV showed that the maximum severity of symptoms was noted in the first day, by the 2–3 day of observation, complaints and fever disappeared. The increase in local reactions was noted 2 days after immunisation, followed by extinction by 3-4 days of follow-up. There were no serious adverse events in the post-vaccination period.

Conclusions: Vaccination with the 13-valent PCV in children with JIA is safe and is not accompanied by the development of serious adverse events.

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AB1092 AN AUDIT ON PAEDIATRIC UVEITIS IN THE GREATER GLASGOW AND CLYDE (GGC) SERVICE: GUIDELINE ADHERENCE AND IMPACT ON PATIENT OUTCOMES

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Background: 10 years guidelines from the Scottish Paediatric and Adolescent Rheumatology Network (SPARN) and the Scottish Uveitis Network (SUN) outlined management pathways for paediatric uveitis. Given the time since its establishment and last review, an audit on the GGC service’s adherence to the guidelines as well as patient outcomes was conducted.

Objectives: To determine the service’s compliance to the SPARN/SUN guidelines for the management of paediatric uveitis, in addition to establishing patient outcomes and identifying current shortcomings and areas for improvement in future practice. We also aimed to provide data to inform the revision and updating of the guideline for the year 2018.

Methods: This retrospective audit was conducted by collecting data from patients within the GGC’s Royal Hospital for Children’s joint rheumatology and ophthalmology service who were diagnosed with uveitis between the 1st of January 2008 and the 31st of December 2017. The data was then compared to the guidelines set by SPARN/SUN, in addition to a study conducted by this service prior to the guideline’s development.

Results: 39 suitable patients were identified from the list of 253. From these patients, 92 separate events of uveitis were recorded – 84 of which ended in remission within the audit period. 17 events (20%) remained active after 7 months and required ongoing treatment, falling out with the guideline’s standards. Time to remission was further stratified by modality of treatment. Of the 78 eyes evaluated, 7 eyes in 5 patients were found to have had cataracts. This comprises 12.8% of patients, an improvement from the 29% of the previous study. Notably, 5 of the 7 eyes had cataracts detected at the first appointment with the service. An additional 7 eyes across 6 patients (15%) were recorded to have had cystoid macular oedema, which is comparable to the previous study’s 11%. A majority of these (4 of 7 eyes, or 57%) were again discovered to already be present at the first appointment.

Conclusions: Guideline adherence was commendable, though improvement is needed in treatment escalation to decrease the time taken for patients to achieve remission. There exists a tendency to maintain patients on topical steroid therapy due to relapsing and remitting disease activity, though given the high risk of glaucoma, consideration should be given to quickly progressing these patients up the treatment ladder. A large proportion of patients with severe complications of uveitis appear to have developed these prior to their first attendance at the service, suggesting a need for more stringent screening processes for early detection. Overall, outcomes in terms of the number of patients affected by complications of uveitis appear to have improved when compared to the study previously conducted by the service, implying a beneficial effect from adherence to the implemented guidelines.

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