Conclusions: Kids can have a variety of musculoskeletal disorders. We feel that management of rheumatological conditions in kids need to be approached in a multidisciplinary way. Genetic disorders mimicking inflammatory conditions need to be considered all time. In those places particularly where paediatric rheumatologists are not available, involvement of paediatricians may be useful. In terms of PPRD, it is commonly mistaken as juvenile rheumatoid arthritis, however there is no inflammatory process going on in PPRD.

REFERENCE:

- [1] NIH, US National Library of Medicine, Genetics Home Reference, Your Guide to Understanding Genetic Conditions

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AB1098

EARLY PROSTHESIS IMPLANTATION IS POSSIBLE IN PATIENTS AFFECTED BY JUVENILE IDIOPATHIC ARTHRITIS, TREATED WITH BIOLOGICS: A MONOCENTRIC EXPERIENCE OF 160 PROSTHESIS FROM THE LAST TWENTY YEARS

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Background: The main reasons for prosthesis implantation in a young patient are post-traumatic osteoarthritis, congenital dysplasia and autoimmune diseases involving joints, like Juvenile Idiopathic Arthritis (JIA). Often, related to particular anatomic conditions and severe grade of deformity, there may be a need for special (custom made or revision) components of prosthesis. Biologic therapy in severe, refractory JIA has permitted to obtain a better control of the disease so as to proceed with prosthesis implantations (hip, knee, ankle).

Objectives: The aim of the study was to present a monocentric experience of a transitional care centre for JIA and the outcome of early prosthesis implantation in patients treated with biologics.

Methods: 160 prosthesis implantation (72 Hip arthroprosthesis, 71 Knee arthroprosthesis and 17 Ankle arthroprosthesis) were performed between 1999 and 2017. It was defined a wash-out period from the biologic therapy depending on the half-life of the medication. The survival of the implant was evaluated for a period of 10 years. We evaluated the different type of implants and it was proposed a radiographic classification for every type of implant.

Results: All patients included in the study were treated with biologics. A long-term analysis of the following ten years of follow-up proved an average survival of 95.5% of the prosthesis and good results in term of function and comfort for the patients. Complications in 2% (two trochanter detachment, two sepsis and one peri-operative haemorrhage).

Conclusions: Prosthesis implantation for JIA patients is a complicated and difficult procedure in comparison with the traditional approach used in patients affected by osteoarthritis. This is related to the management of the biologic therapy, the low quality of the bone, the remarkable stiffness and deformity of the joints. Long-term results were good, even in patients with severe arthritis. There was a drastic reduction of articular pain and an improvement of functionality. Prosthesis implantation in patients with active disease and mild or bad response to the biologics had a worse outcome. The use of not cement-retained implants doesn't influence the long-term survival at ten years, similar to that of the adult patients affected by osteoarthritis.

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AB1099

AN AUDIT ON THE SCREENING GUIDELINES FOR UVEITIS IN CHILDREN WITH JUVENILE IDIOPATHIC ARTHRITIS WITHIN THE ROYAL HOSPITAL FOR CHILDREN, GLASGOW

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Background: Juvenile Idiopathic Arthritis (JIA) defines many arthropathies occurring in children which persist for at least 2 weeks. All JIA patients are at risk of developing uveitis, an inflammatory condition of the eye which poses a risk to visual impairment. The British Society of Paediatric and Adolescent Rheumatology outline guidelines for the screening of these patients. Given the time since publication, an audit on the adherence to said guidelines, as well as patient outcomes, was conducted.

Objectives: Our aim was to identify adherence to the screening guidelines within the RHC, Glasgow; and to what extent adherence to these guidelines prevented the occurrence of uveitis. We aimed to identify areas which could be improved within the Glasgow service itself, as well as providing data for the revision of the guidelines.

Methods: We performed a clinical audit of all JIA patients diagnosed between 1st January 2008 and 31st December 2017, analysing the frequency and adherence of appointments, as well as medication use. Data was gathered from patient medical files and collected into a database for analysis.

Results: 97 of 115 JIA patients entered the screening programme. 72 patients had their initial eye screen within the appointed guidelines of 6 weeks, and 13 of the patients were examined under anaesthetic, with a mean time to examination of 3.31 weeks (0–7.14).

15 patients were seen according to the two-monthly guidelines for the first 6 months of diagnosis. Following this 6 month period, it is suggested patients are screened every three to four-months. 463 out of 641 (72.2%) appointments met this guideline.

After stopping immunosuppressive therapy, it is advised to screen at two-monthly intervals. 97 patients were treated with immunosuppressants, with 10 patients stopping whilst still in the screening service. 9 continued to be seen on a three to four-month basis as before, 1 patient was not screened at all, but no patients were screened according to the guidelines.

Conclusions: Adherence to the screening service could be improved, with 75% of patients having had their first screen within the guideline criteria, and 72% seen within the guidelines following the initial 6 months. It seems that improvement mainly needs to be focussed on the methods of appointment rearrangement.

There is believed to be a 6 month high-risk period of developing uveitis following cessation of immunosuppressants, thus increased screening is suggested. This was not adhered to well in the Glasgow service, but there was no increased risk of uveitis development found, suggesting the need for alteration to the guidelines.

REFERENCES:

- [1] British Society for Paediatric and Adolescent Rheumatology (2006) *Guidelines for Screening for Uveitis in Juvenile Idiopathic Arthritis (JIA)*: BSPAR
- [2] Ross E Petty, Taunton R Southwood, Prudence Manners, John Baum, David N Glass, Jose Goldenberg, et al. *International League of Associations for Rheumatology classification of juvenile idiopathic arthritis: second revision*, Feb 2004 ed.: The Journal of Rheumatology; 2004
- [3] Muthappan, V; Feldman, B H. Juvenile Idiopathic Arthritis: Uveitis. *American Academy of Ophthalmology* 2015

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AB1100

EPIDEMIOLOGY AND MANAGEMENT PRACTICES FOR CHILDHOOD-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS: A SURVEY IN LATIN AMERICA

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Background: Two groups have reported data focused on epidemiology, clinical and laboratorial features of childhood-onset systemic lupus erythematosus (cSLE) patients in Latin America (LA): BRAC-SLE (Brazilian Childhood-onset SLE Registry Group) and GLADEL (Grupo Latino Americano De Estudio del Lupus). However, to the best of our knowledge, epidemiology and management of cSLE based on LA Paediatric Rheumatologists (LAPR) were not carried out.

Objectives: Therefore, the objective of the present cross-sectional survey study was to assess LAPR reports of cSLE patients regarding epidemiology, classification criteria, disease activity and other instruments used in clinical practices, laboratory and other exams availability, general supportive care, drugs availability, infections, non-live vaccines, issues observed in adolescents, reproductive health issues and transition-focused program to adult care.