con founding by treatment. Consecutive bacteremic patients were identified from an associated paediatric intensive care unit over the same period. Descriptive statistics and univariate logistic analyses were performed as appropriate.

Results: Patient characteristics are summarised in Table 1; bacteremic patients were younger. PCT was elevated in bacteremic patients, and was undetectable in all other subjects (Table 2). There were trends towards higher ESR and CRP in bacteremic patients, but these were not statistically significant.

Conclusions: Serum PCT levels appear to be a reliable biomarker to distinguish infection vs. active JIA at presentation, and can aid in directing therapy. However, PCT does not appear useful to assess disease activity in JIA. Further studies are needed to assess utility of serum PCT measurement in differentiating JIA flares from less severe infections.


Disclosure of Interest: None declared

AB1119 CLINICAL, THERAPEUTIC CHARACTERISATION AND TIME TO ACHIEVE REMISSION ANALYSIS OF A COLOMBIAN COHORT WITH JUVENILE IDIOPATHIC MYOPATHY
1Rheumatology Department, 2Clinical Research, Arctmedica; 3National University of Colombia, Medellín, Colombia

Background: The clinical characteristics of paediatric patients with idiopathic inflammatory myopathies differ from adults in several aspects. Its clinical presentation can include amyoplastic onset and the skin involvement has different characteristics.

Objectives: To describe a Colombian cohort with Juvenile Myositis (JIM) recruited in a rheumatology facility.

Methods: A cross-section retrospective research with data collected between 2014 and 2017 from a population diagnosed before 16 years of age with Idiopathic Myopathy according to Peter and Bohan criteria and followed up for at least six months. Kaplan-Meier curves were performed to analyze time to achieve remission.

Results: Out of 37 patients, one was excluded for having a dystrophy myopathy gene, 73% fulfilled definitive and 16% probable Bohan and Peter criteria; most patients were female 75.8%, with mean age of onset 7.2 years, and clinical remission was achieved on average at 4 years of disease. There was high prevalence of Gottron’s sign and papules (89%), Heliotrope rash (62%) and Calcinosis (37%). Other involvements are described in Table 1. Antinuclear antibodies were present in 52%. Electromyography (EMG) was positive for myopathy in 39% of the patients. Biopsy was compatible with myopathy in 10% and was negative in 32% of the patients. The most common treatment was methotrexate (91%) followed by antimalarials (72%) and corticoids (56.7%). Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. Medication used in severe disease included cyclophosphamide (5%), Rituximab (16%) and IV Immunoglobulin and antimalarials followed by antimalarials and 56.7%. 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