inflammatory back pain (IBP) obtained from rheumatological system questionnaire in the patients' charts were recorded. The x-ray and MR images of sacroiliac joint registered in the PACS system were evaluated by a Rheumatologist. Patients with inflammatory low back pain and sacroiliitis detected by X-ray or MR were included in the FMF with axial spondylarthritis (FMF-SPA) group and others to FMF group. The frequency of MEFV gene mutations were compared between two groups.

Results: The frequency of M694V, M680I, V726A, E148Q and R202Q were 82.4%, 19.6%, 16.7%, 10.8% and 16.7% respectively in FMF group and 78.6%, 21.4%, 14.3%, 21.4% and 28.6% respectively in FMF-AS group. There was no significant difference between groups ($p=0.716$, $p=1.000$, $p=1.000$, $p=0.373$ and $p=0.279$ respectively). The frequency of M694V homozygotes and heterozygotes mutations were 27.5% and 21.6% respectively in FMF group and 35.7% and 7.1% respectively in FMF-SPA group and difference between groups was not significant ($p=0.537$, $p=0.296$ respectively).

Abstract AB1146 – Table 1. The characteristics and MEFV gene mutations of FMF patient with spondylarthritis

	Age, years	Sex	IBP	Sacroiliitis X-ray/MR	MEFV mutations
1	34	F	+	-/+	M694V/M680I
2	41	F	+	-/+	M694V/M694V
3	31	F	+	+/ND	E148Q/R202Q
4	56	M	+	+/ND	M680I/E148Q
5	49	M	+	+/ND	M694V/-
6	47	M	+	+/ND	M694V/E148Q
7	22	M	+	+/ND	M694V/M680I
8	22	F	+	+/ND	M694V/M694V
9	39	F	+	+/ND	M694V/M694V
10	30	M	+	+/ND	M694V/M694V
11	37	M	+	+/ND	M694V/M694V/R202Q/R202Q
12	41	F	+	+/ND	M694V/R202Q/A744S
13	24	F	+	-/+	V726A/K695R
14	31	F	+	+/ND	M694V/V726A/R202Q

ND: Not done, IBD: inflammatory back pain

Conclusions: The frequency of common MEFV gene mutations in this study is not different between FMF patients with and without axial spondylarthritis. Increased frequency of axial spondylarthritis in FMF patients may not be associated with MEFV gene mutations.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6721

AB1147 EVOLUTIONARY STUDY OF 45 CASES OF UNDIFFERENTIATED NEGATIVE HLA B27 SERONEGATIVE OLIGOARTHRITIS

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Background: The prognosis of patients with undifferentiated arthritis may vary from self-limited to severe destructive rheumatoid arthritis. Early diagnosis is important, specially in seronegative oligoarthritis in order to start a treatment as early as possible.

Objectives: To describe the evolution of patients older than 16 years diagnosed with negative HLA B27 seronegative oligoarthritis without axial involvement.

Methods: We retrospectively studied 45 patients (23 women, 22 men) with negative HLA B27 seronegative oligoarthritis without axial involvement who debuted between 1985 and 1990 and who did not meet the criteria for any of the rheumatic diseases at the time of debut: rheumatoid arthritis (AR), psoriatic arthropathy (PsA), spondyloarthropathy, enteropathic arthritis, reactive arthritis, microcrystalline arthritis or connective tissue disease.

Results: The mean age at onset of oligoarthritis was 42.2 years (range 17–66). The mean follow-up time was 13.7 years (range 1–32). In its evolution, a definitive diagnosis was reached in 21 (46.6%) patients, with the mean time between debut and diagnosis being 5.47 years (range 1–25): 8 AR, 4 APs (3 with involvement) peripheral and 1 mixed), 2 undifferentiated spondyloarthritis, enteropathic arthritis, 5 gouty arthropathies and one SLE. In the case of RA, the diagnosis was made on an average of 4.8 years after the debut (range 1–16); the RF was positive in 4 patients a mean of 7.6 years (range 3–11) after the debut, and the anti-CCP were positive in 3 of the patients with positive RF. Within PsA, one developed skin psoriasis, another psoriatic onychopathy at 4 years after debut and 2 continue without skin involvement but with a family history of psoriasis, all met CASPAR criteria. From the other 24 patients (53.3%), only 3 patients (12.5%) continued to be followed up, with an average of 21.3 years (range 18–26) without meeting the criteria that allow us to define diagnosis. With the rest of the patients (40.8%), followed for an average of 4.5 years, a diagnosis was not achieved by resolution of the clinical picture or loss of follow-up.

Conclusions: In our series, 46.6% of the patients with a diagnosis of negative HLA B27 seronegative oligoarthritis began to meet diagnostic criteria for rheumatic disease after a mean time of 5.47 years, with RA being the most frequent diagnosis (38%) after an average of 4.8 years after the arthritis onset.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6004

AB1148 BIOLOGICAL TREATMENT OF NON ISCHAEMIC OPTIC NEURITIS ASSOCIATED TO IMMUNE-MEDIATED INFLAMMATORY DISEASES. MULTICENTER STUDY

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Background: Non ischaemic optic neuritis (NION) is a severe inflammation of the optic nerve that may lead to blindness. It can be primary or associated to immune-mediated inflammatory diseases (IMIDs). The treatment of the NION is based on systemic corticosteroids and conventional immunosuppressive drugs.

Objectives: To assess the efficacy of the biological treatment in refractory NION to conventional treatment.

Methods: Multicenter study of 8 patients diagnosed with NION refractory to systemic corticosteroids and at least one conventional immunosuppressive drug.

The main outcomes were visual acuity (VA) and OCT of the optic nerve and the ganglionar cells. Comparisons were made between baseline and the 1st week, 1st and 6th month and 1st year. (STATISTICA, StatSoft Inc. Tulsa, Oklahoma, USA).

Results: We studied 8 patients (12 affected eyes) (4♀/4♂); mean age of 34.37 ±13.30 years. The underlying diseases were SLE (n=1), neuromyelitis optica (n=1), neuroretinitis (n=1), relapsing polychondritis (n=1), idiopathic (n=2) and Behçet's disease (n=2).

Before biological treatment and besides oral corticosteroids patients had received intravenous (IV) methylprednisolone boluses (n=6), cyclosporine A (CyA) (n=1), cyclophosphamide (n=2), micophenolate (n=2), hydroxychloroquine (n=1), methotrexate (MTX) (n=4) and azathioprine (AZA) (n=2).

Biological treatment was based on rituximab (n=2) (2 IV. doses of 1 g/very 2 weeks and every 6 months), adalimumab (n=2) 40 mg/week, tocilizumab (n=2) 8 mg/kg/2–4 weeks and infliximab (n=2) 5 mg/kg at 0, 2 and 6 week and then every 8 weeks.

The characteristics of the 8 patients are shown in the **TABLE**

After biological treatment we observed an improvement in the ocular parameters: VA [0.60±0.33 to 0.76±0.41, $p: 0.04$], OCT of the optic nerve [130.63±60.54 to 102.60±18.17, $p: 0.1$] and OCT of the ganglionar cells [404.60±184.73 to 243 ±18.38, $p: 0.17$] at one year. After a mean follow-up of 27±14.47 months there were no severe adverse effects.

Abstract AB1148 – Table 1

Case	Sex / Age (years)	Underlying disease	Laterality	Immunosuppressive drugs before biologic therapy	Biologic therapy
1	♂ / 25	Behçet's disease	Right	MTX, CyA	ADA
2	♂ / 43	Neuromyelitis optica	Bilateral	AZA	RTX
3	♂ / 14	Neuroretinitis	Bilateral	MTX	ADA
4	♀ / 56	SLE	-	HYDROXYCHLOROQUINE, MMF, CFM	RTX
5	♀ / 29	Idiopathic	Right	AZA	TCZ
6	♀ / 26	Idiopathic	Bilateral	AZA	TCZ
7	♀ / 43	Relapsing polychondritis	Bilateral	MTX, CFM	IFX, TCZ
8	♂ / 39	Behçet's disease	Right	MTX, MMF	IFX

MTX: methotrexate, CyA: cyclosporine A, AZA: azathioprine, CFM: cyclophosphamide, MMF: mycophenolate, ADA: Adalimumab, RTX: rituximab, TCZ: tocilizumab, IFX: infliximab.

Conclusions: This study shows that treatment with biologic drugs, including anti-TNF drugs, in NION associated to IMIDs, refractory to conventional treatment, seems to be effective. These results must be confirmed in prospective and randomised trials.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.5485

AB1149 CYSTIC FIBROSIS AND INFLAMMATORY ARTHRITIS REQUIRING IMMUNOSUPPRESSION: A WORRYING COMBINATION?

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Background: Inflammatory arthritis is a recognised complication of cystic fibrosis (CF) with an estimated prevalence of 2.3^[1] to 8.5%^[2] of CF patients. Cystic fibrosis associated arthritis (CFA) constitutes the majority of this, but other there may be other co-morbid rheumatic disease. Concerns about use of immunosuppression in the context of chronic pulmonary infection, and consequent risk of destabilisation, may limit use of these medications when clinically indicated. Immunosuppressive therapy is used in patients with CF lung disease who have inflammatory rheumatic disease, inflammatory bowel disease, or who have had a liver transplant for CF-related liver disease. Some data on those receiving immunosuppression post-transplant has been published and reassuringly reported fewer courses of intravenous antibiotics following transplant.^[3] Reports of immunosuppressants being used in other contexts, including arthritis, are more sporadic.

Objectives: To assess prior use and safety outcomes of immunosuppressant therapy in adults with CF.

Methods: A retrospective case note review of patients with CF receiving disease modifying anti-rheumatic drugs from 2 large adult CF centres (total >700 patients) from electronic records spanning 3–10 years.

Results: 41 patients were identified: 7 post liver transplant, 1 with inflammatory bowel disease, 1 with IgA nephropathy; 32 with inflammatory arthritis.

Abstract AB1149 – Table 1

Medication	Number of patients	Cumulative months of treatment	Stopped due to side effects
Azathioprine	4	239	0
Hydroxychloroquine	27	726	3
Sulfasalazine	7	98	3
Tacrolimus	7	900	0
Methotrexate	6	192	1
Cyclophosphamide	1	1	0
Etanercept (with methotrexate, sulfasalazine, hydroxychloroquine)	1	7	0

There was one possible case of increased pulmonary exacerbation associated with methotrexate; they remained on treatment at the time of the study. There was no evidence that immunosuppression resulted in a fall in lung function necessitating cessation of treatment in any of these cases. Three patients stopped hydroxychloroquine and 1 patient stopped methotrexate due to non-respiratory side effects. Four of 7 patients responded to treatment with sulfasalazine for inflammatory arthritis, 3 stopped due to non-respiratory side effects.

Conclusions: No patients had immunosuppression stopped because of deterioration in lung disease. Steroids were not included in this analysis because duration and dose varied widely. However, it is important to note that they are frequently used in CF (particularly for allergic bronchopulmonary aspergillosis). Indeed 14% of all CF patients in these centres have had steroids in the last 6 months, of whom nearly half received a course of more than 6 months duration.

Whilst our results are reassuring, the numbers remain small. Decisions must be made in conjunction with the multidisciplinary team, but CF in itself should not delay or stop treatment with immunosuppression where it is indicated.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2992

AB1150 THE EUROPEAN REFERENCE NETWORK ON RARE AND COMPLEX CONNECTIVE TISSUE AND MUSCULOSKELETAL DISEASES: ERN RECONNET

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Background: Set up under the European Union (EU) directive on patients' rights in cross-border healthcare (2011/24/EU), European Reference Networks (ERNs) on rare and complex diseases are aimed at connecting healthcare providers (HCPs) across different EU Countries to tackle complex and rare medical conditions that require highly specialised treatment. ERN ReCONNET, endorsed by EULAR, and approved for rare and complex connective tissue diseases (CTDs), aims at developing a framework for the delivery of high quality, innovative, sustainable and equitable standard of care and practice for better access to care of European patients.

Objectives: To report the activities of ERN ReCONNET during the first 10 months of work

Methods: ERN ReCONNET is composed of 26 HCPs from 8 EU Countries: Belgium, France, Germany, Italy, Netherlands, Portugal, Romania and Slovenia. Patients involvement is ensured by the ERN ReCONNET European Patients Advocacy Group, included in the activities of the ERN. The diseases covered are divided into 3 main thematic areas: rare CTDs (systemic sclerosis, mixed CTD, idiopathic inflammatory myopathies, antiphospholipid syndrome, undifferentiated CTD, IgG4 related diseases, relapsing polychondritis), complex CTDs (SLE, Sjögren's Syndrome), hereditary connective tissue diseases (Ehlers-Danlos syndrome). Senior and Junior Coordinators for each disease were selected. The scientific activities of ERN ReCONNET officially started in Vilnius in March 2017, where the 24 ERNs have been formally launched.

Results: The scientific activities of the first year were mainly focused on existing clinical practice guidelines (CPGs). The first phase was aimed at identifying the scientific publications, selecting them by evaluation of titles and abstracts, and by reviewing the full texts. More than 6.000 publications have been screened. The second step was to review critically the articles according to the principles of the AGREEII flow-chart. This work allowed to identify CPG for the majority of the diseases covered by ERN ReCONNET, as well as unmet needs, in particular for the rarest diseases (IgG4 related diseases, relapsing polychondritis, mixed CTD). Good progress has also been made in the field of IT, in which ERN ReCONNET was mainly focused on the use of the Clinical Patients Management System web-platform, designed for the interactive discussion of difficult clinical cases. Notably, the creation of ERN website is being co-designed by all Networks stakeholders.

Conclusions: The ERN ReCONNET will significantly improve the clinical approach to rare and complex CTDs, promoting an improvement of the quality of the specialised care provided to patients, of the activity of the physicians, the empowerment of the patients sharing expertise and promoting the interaction among EU HCPs. All these activities are addressed to create a highly specialised network, in which the knowledge travels rather than the patient.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6341