SP0159 EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF SJÖGREN'S SYNDROME

S. Retamozo^{1,2}. ¹Department of Autoimmune Diseases, ICMiD, Laboratory of Autoimmune Diseases Josep Font, IDIBAPS-CELLEX, Hospital Clínic, Barcelona, Spain; ²Rheumatology Unit, Hospital Privado Universitario de Córdoba. Instituto De Investigaciones En Ciencias De La Salud (INICSA), Consejo Nacional de Investigaciones Científicas y Técnicas (CONICET) – Córdoba – Argentina., Córdoba, Argentina

Sjögren's syndrome (SjS) is a systemic autoimmune disease that affects 0.1% of the European population and that presents with a wide spectrum of clinical manifestations. Primary SjS has no cure, and their therapeutic management has not changed significantly over the past decades. The current approach is still based upon symptomatic treatment of sicca symptomatology and broad-spectrum immunosuppression directed against systemic disease. In spite of the several therapeutic options available, there is insufficient information on their differential efficacy and safety, making that treatment decisions remain challenging in clinical practice. Over the last decade, research has centred on investigating more effective SS-targeted therapies, with the development of various randomised controlled trials (RCT) unfortunately with the absence of game-changing results. With these discouraging results, national effort promoted by some scientific societies have led to the development of several sets of recommendations.

The European League Against Rheumatism (EULAR) promoted and supported in 2010 an international collaborative study (EULAR SS Task Force) aimed at developing consensual disease activity indexes in SS. This work was very successful with the development of the first international specific scores for SjS (ESSPRI and ESSDAI), now widely used both in clinical and research settings. The wide consensus obtained on the development of the ESSDAI/ESSPRI scores provided an excellent opportunity to advance in the development of international recommendations for the therapeutic management of SS. Therefore, we continued the work of the Task Force with the development of evidence-, consensus-based official EULAR recommendations following the Delphi methodology, with the aim to provide physicians and patients with a rational therapeutic approach to SjS patients.

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SP0160 2018 EULAR RECOMMENDATIONS FOR THE USE OF GLUCOCORTICOID THERAPY

F. Buttgerit. Department of Rheumatology and Clinical Immunology, Charité University Medicine Berlin, 10117 Berlin, Germany

Glucocorticoids (GC) are potent anti-inflammatory and immunosuppressive drugs which are used successfully to treat many disorders, including rheumatoid arthritis, polymyalgia rheumatica, giant cell arteritis, myositis, systemic lupus erythematoses and other rheumatic diseases. However, these drugs also have the potential to cause severe adverse effects, particularly if high doses are used for prolonged periods. Therefore, the benefits of GC therapy must be balanced against the potential risks. Key strategies to achieve this goal include (i) following guideline recommendations regarding GC therapy dosing, monitoring for potential adverse events, and adverse event prevention and management, (ii) using or developing new therapeutic advances to improve the therapeutic balance.

The EULAR Glucocorticoid Task Force has already published several recommendations over the last years such as those on the standardised nomenclature for GC dosages and treatment regimens, on the management of systemic GC therapy in rheumatic diseases, and on monitoring adverse events of low-dose GC therapy. Recent work of this group dealt with the question under which conditions long-term treatment with GC has an acceptably low level of harm. As a result, the task force members agreed that the risk of harm is low for the majority of patients at long-term dosages of ≤5 mg prednisone equivalent per day, whereas at dosages of >10 mg/day the risk of harm is elevated. At dosages between >5 and ≤10 mg/day, patient-specific characteristics determine the risk of harm. This means general and glucocorticoid-associated risk factors and protective factors such as a healthy lifestyle should be taken into account when evaluating the actual and future risk.

Another new information on the use of GCs has been recently provided by EULAR 2016 update of RA recommendations: "Short-term GCs should be considered when initiating or changing csDMARDs, in different dose regimens and routes of administration, but should be tapered as rapidly as clinically feasible." This wording does acknowledge that there are several different regimens for oral use, intramuscular injection, and intravenous pulse therapy. It is now also being stated more clearly that GCs should be given as bridging therapy together with csDMARDs, either as part of the initial strategy or subsequently if this has failed.

In contrast, GCs are usually not needed as a bridging therapy when bDMARDs or tsDMARDs are used. This recommendations reconfirms that GCs should be gradually reduced and ultimately stopped, ideally within 3 to 6 months.

Finally, the role of GCs in the management of polymyalgia rheumatica as has been described and discussed by the recent EULAR/ACR recommendations will be briefly discussed.

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SP0161 2018 EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF HAND OSTEOARTHRITIS

M. Kloppenburg, on behalf of Task force for the update of EULAR recommendations for the management of hand osteoarthritis. *Rheumatology, Leiden University Medical Center, Leiden, Netherlands*

Hand osteoarthritis is a prevalent osteoarthritis phenotype, with high disease burden. With regard to the management of patients with hand osteoarthritis European League Against Rheumatism (EULAR) recommendations have been formulated in 2007. However, new evidence has emerged and therefore the recommendations have been updated by an international task force of experts, including rheumatologists, health professionals, plastic surgeon and patient representatives.

First, a systematic literature review was performed, collecting evidence regarding non-pharmacological, pharmacological and surgical treatment options. Second, based on the evidence and expert opinion, five overarching principles were formulated, referring to treatment goal, information provision, individualised treatment, shared-decision making and need to consider multidisciplinary and multimodal treatment approaches. In addition ten recommendations were formulated, describing non-pharmacological, pharmacological and surgical options, and considerations about follow-up. Finally, a level of evidence, grade of recommendation and level of agreement were allocated by all experts to each statement.

With the updated EULAR recommendations evidence-based up-to-date guidance can be provided on the management of hand OA.

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Fractures: more than bone alone**SP0162 LOOK AT THE CASCADE : CLINICAL OBSERVATIONS**

K. Briot. *Rheumatology, Cochin Hospital, Paris, France*

Vertebral fracture (VF) is the most common osteoporotic fracture, and a strong risk factor of subsequent vertebral fracture. Prospective studies have shown that a recent VF increases an imminent risk of a subsequent one, and attention has been paid recently to a possible cascade phenomenon i.e. the occurrence of multiples VFs in less than one year after discontinuation of denosumab (rebound vertebral fractures) in postmenopausal osteoporosis and in patients receiving aromatase inhibitors. Vertebral fracture cascade has been reported in secondary causes of osteoporosis (after the initiation of systemic glucocorticoids, in endocrine disease, benign hemopathies as mastocytosis and in pregnancy-and lactation-associated osteoporosis). We reported the clinical observations of patients with multiples vertebral fractures occurring over one year and we discussed the causes, the potential risk factors and the appropriate management.

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SP0163 A CASE OF SEVERE OSTEOPOROSIS AND ISCHAEMIC HEART DISEASE; WHAT WILL BE THE FUTURE CARDIOVASCULAR RISK?

G. Weerasinghe, on behalf of Fracture prevention service, Oxford. *Oxford University Hospitals NHS Trust, Oxford, UK*

Case description: A 63-year-old female recently presented to metabolic bone clinic with vertebral fractures at L4 and L5. DEXA scan showed osteoporosis with T-scores at the spine -4.0 and left hip -3.8. Patient was commenced on weekly