Conclusions: The contrast-enhanced MRI scores for the assessment of synovial enhancement and synovial inflammation in the wrist of clinically active JIA patients appear valid. Due to a low incidence of wrist tenosynovitis in this cohort, the validity of the tenosynovitis score could not be assessed. These findings further establish contrast-enhanced MRI as a diagnostic tool with synovitis as the primary target of disease in the wrist of JIA patients.

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THU0580 THE ACR RECOMMENDATIONS FOR JIA IN DAILY CLINICAL PRACTICE: ARE THEY FOLLOWED OR WOULD TREAT-TO-TARGET THERAPY LEAD TO BETTER RESULTS?

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Background: What factors drive the physician decision to escalate to anti-TNF therapy 3 and 6 months after start of methotrexate (MTX) in both persisting oligoarthritis (OJA) and polyarticular course (PJIA) juvenile idiopathic arthritis.

Objectives: Are the escalation-decisions in accordance with the ACR JIA treatment recommendations (ACR-CPG)¹ and if not, what factors drive these decisions. How does it perform as a "prognostic" test to predict failure when not escalated. Could the clinical Juvenile Arthritis Disease Activity Score (cJADAS) be used instead. What is the value of the patient-VAS in the ACR-CPG, the physician decision and in the cJADAS.

Methods: Monocentric retrospective cohort study analysing all OJA and PJIA patients starting MTX for the first time between 2011 and 2016.

Results: The ACR-CPG is mostly not followed and implementation would increase the anti-TNF-use from 12.0% to 65.1%. However, the physician decision not to escalate was now correct in 70%–75%, therefore implementation results in an overuse of anti-TNF. Some items of the ACR-CPG were non-discriminatory. The use of cJADAS in predicting failure if not escalated outperformed the ACR-CPG with a much higher sensitivity and specificity for the OJA and PJIA group respectively. The omission of the patient-VAS-scores resulted in a substantial decrease of the identification of patients failing to respond without escalation.

Conclusions: The ACR-CPG not only is too complicated to be applicable in clinical practice, it also fails to identify those patients really in need of escalation to

anti-TNF. The cJADAS can be used instead since this is user-friendly, does not require waiting for ESR results and performs better than the ACR-CPG. The patient-VAS is a critical item for the decision to escalate.

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THU0581 USE OF BIOLOGICAL THERAPIES IN ADULT PATIENTS DIAGNOSED WITH JUVENILE IDIOPATHIC ARTHRITIS: RESULTS FROM BIOBADASER, THE SPANISH REGISTRY OF ADVERSE EVENTS WITH BIOLOGIC THERAPIES

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Background: Juvenile idiopathic arthritis (JIA) is the most frequent chronic rheumatic disease in childhood. The early disease recognition and treatment is critical to prevent long-term complications and disability in childhood. During the last decade the arrivals of biologics has dramatically changed the prognosis of these patients. A number of well-designed clinical trials, as well as cohort studies have demonstrated that biologics are an effective option for JIA patients who do not respond or cannot tolerate treatment with synthetic disease modifying drugs (DMARDs).

JIA is not confined to childhood, and a 41% had active disease are on medication after 30 years and 28% had a high symptom state.

Objectives: The aim of this work was to study the pattern of use, drug survival and adverse events of biologic therapy in JIA patients during the transition period from the diagnostic to the adulthood.

Methods: Information was obtained from BIOBADASER, a safety multicenter prospective registry. All patients included in the registry diagnosed of JIA between 2000 and 2015 were analysed. Proportions, means and standard deviations (SD) were used to describe population. Incidence rates and 95% confidence intervals were calculated to assess adverse events. Kaplan-Meier analysis was used to compare the drug survival.

Results: 469 patients, 46.1% women were included in this study. Age at diagnosis was 9.4 (SD=5.3) and years of disease evolution 24.1 (SD=14.1). The age at biological treatment initiation was 23.9 years (SD=13.9). The pattern of use of biologics in JIA patients in the paediatric age shows a linear increase from 24% in 2000 to 65% in 2014. Interestingly, the biologic suspension for disease remission was higher in patients who initiated its use under 16 years (25.7%) than in those who began at 16 years or later (7.9%, p<0.0001). Serious adverse events showed a total incidence rate of 41.4 (35.2–48.7) (1000 patients/year) without differences between patients younger or older than 16 years old. However, patients younger than 16 years old showed a significant increment in infection and infection (p<0.001).

Conclusions: The biologic survival and suspension by remission was higher when the biologic therapy started before 16 years old in JIA patients. The incidence rate severe adverse events in the childhood and adulthood in JIA patients treated with biologics was similar, however, a significant increment of infection was observed in patients under 16 years old.

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