One of our patients reported that her psoriatic lesions got worse on anakinra. Forty-one patients reported no adverse events during the treatment.

Conclusions: Anakinra was effective in controlling the symptoms in colchicine-resistant FMF cases. It was also effective in FMF related amyloidosis. The major cause of treatment termination was injection site reactions. Anakinra seems to be an effective alternative in patients who have insufficient response to colchicine.

Disclosure of Interest: None declared

THU0612

BONE SARCOIDOSIS: A RETROSPECTIVE MULTICENTER STUDY OF 27 CASES
C. Glanowski1, R. Mestiri2, L. Bialé1, T. Carmol1, D. Lechevaller1, G. Leroux2, D. Saadoun1, C. Chapelon-Abric1, P. Cacoub3, Rheumatology, Internal Medicine, Hôpital Bégin, Saint Mandé; 2Internal Medicine, Hôpital de la Pitié Salpêtrière, Paris, France

Background: Studies on bone involvement of sarcoidosis (BS) are scarce.

Objectives: To analyse in depth main features, treatments and follow up of patients presenting a BS.

Methods: Among 926 patients with a proved sarcoidosis from four tertiary hospitals in Paris (France) seen between 2000 and 2015, all cases of BS were retrospectively analysed for demography, clinical features, biological tests and imaging results. Inclusion criteria were a) a bone biopsy with epithelioid granuloma and no casein necrosis, or b) radiological evidence of BS, after exclusion of other diagnoses.

Results: 27 out 926 (2.9%) sarcoidosis patients fulfilled inclusion criteria for BS. Most patients were caucasian (56%), M:F sex ratio 1.5, 30% were active smokers, mean age at sarcoidosis diagnosis was 39±12 years and at BS diagnosis 43±11 years. Extra-osseous BS involvement was found in lymph nodes (93%), lungs (78%), skin (52%), CNS (33%), ENT (33%), and heart (19%). BS was symptomatic in 15/27 (56%) patients i.e. bone pain (15/15), local inflammation (5/15), bone deformation (3/15), arthritis (4/15), and myalgia (5/15). BS was never the revealing symptom of sarcoidosis. BS was more frequently symptomatic (93%), lungs (78%), skin (52%), CNS (33%), ENT (33%), and heart (19%). BS was symptomatic in 15/27 (56%) patients i.e. bone pain (15/15), local inflammation (5/15), bone deformation (3/15), arthritis (4/15), and myalgia (5/15). BS was never the revealing symptom of sarcoidosis. BS was more frequently symptomatic (93%), lungs (78%), skin (52%), CNS (33%), ENT (33%), and heart (19%). BS was symptomatic in 15/27 (56%) patients i.e. bone pain (15/15), local inflammation (5/15), bone deformation (3/15), arthritis (4/15), and myalgia (5/15). BS was never the revealing symptom of sarcoidosis.

Conclusions: Bone involvement remains a rare manifestation of sarcoidosis. It was symptomatic in 56% of patients, mainly when Perthes-Jünglingostitis and an appendicular skeleton involvement. On imaging exams, BS lesions were found at the spine skeleton alone (14/27, 52%), appendicular skeleton alone (10/27, 37%) or both (3/27, 11%). BS lesions had an aspect of pseudo-metastasis (59%), micro-cysts (Perthes-Jungling, 37%) or Paget disease (4%). Bone lesion was in complete (8/27, 30%), partial (16/27, 59%) or nul (3/27, 11%). Of note, 21 out of 27 patients had more than 10 lesions. When a bone biopsy was done it was always confirmed the diagnosis (n=9); in all other cases extra-osseous biopsies confirmed the diagnosis of sarcoidosis.

Disclosure of Interest: None declared

THU0614

INTERSTITIAL LUNG DISEASE IN PATIENTS WITH ANTISYNTHETASE SYNDROME AND ANTI-RO52 ANTIBODIES POSITIVE
C. Aquilera Cruz1, A. Ruiz Román1, L. Méndez Díaz2, G. Morote Ibarrola2, R. Barrios Puñal3, M. Arcila Durán1, M.A. Montes Cano1, J.A. Rodríguez Portal4, 1Rheumatology, University Hospital Virgen del Rocio; 2Rheumatology, Quirón Sacred Heart Hospital; 3Immunology; 4Pneumology, University Hospital Virgen del Rocio, Seville, Spain

Background: Antisynthetase syndrome (ASS) is characterised by the presence of myositis, arthritis, interstitial lung disease (ILD), fever, Raynaud’s phenomenon and mechanic’s hand, in the presence of antisynthetase autoantibodies (AA), the most frequent being anti-Jo1, anti-PL7 and anti-PL12. An association between ASS and anti-Ro52 with increased ILD has been described and it is believed that the presence of both antibodies is accompanied by a more severe ILD.

Objectives: To describe the clinical and analytical characteristics of a cohort of patients with ASS. To analyse the lung involvement in this type of patient and to determine the possible relationship between the different subtypes of ILD and the presence of anti-Ro52.

Methods: Retrospective descriptive study of patients treated in our Hospital (2006–2017), with AA and at least 2 clinical characteristics. The data was obtained through the review of medical records.

Results: We included 27 patients (20 women), mean age 61±13 years. 7.4% smokers and 15.8% ex-smokers. 88.8% were anti-Jo1, 7.4% anti-PL12 and 3.7% anti-PL7. Anti-Ro52 present in 18 patients. The most common clinical presentation:ILD 88% (59% had Ro52), followed by myositis 85% (40% are dermatomyositis), arthritis 81%, mechanic’ hand 51%, fever 37% and Raynaud’s phenomenon 25%. The classic triad (arthritis, myositis, ILD) was present in 16 patients. Three patients presented neoplasia in the course of the disease, being identified as PS. Elevation of CK in 70% and aldolase in 74%, 96% of patients have been treated with GC and IS. The HRCT patterns were non-specific interstitial pneumonia (NSIP) (66%), usual interstitial pneumonia (UIP) (29%), organising pneumonitis (OP) (4%), baseline RFT were performed in 19 patients. Diagnosis of ASS and ILD, both entities appear at the same time in 6 patients, in 3 patients the ILD appears before and in 14 after. In these, the median duration (range) of the ASS until the diagnosis of ILD was 1 year (0–1).

There is no relationship between the HRCT and anti-Ro52 patterns (chi-square considering the exact distribution p=0.892), nor between the ILD and anti-Ro52 (Fisher exact test p=0.999).

Conclusions: Our results, in general, agree with what is published in the literature.

Disclosure of Interest: None declared

THU0613

THE FREQUENCY AND CHARACTERISTICS OF HEADACHE IN BEHCET’S DISEASE AND ITS EVALUATION BY TRANSCRANIAL DOPPLER ULTRASONOGRAPHY
F. Saligü2, D. Uskudar Cansu3, U. Uzuner2, C. Korkmaz2, 1Internal Medicine, Endocrinology, Kent Hospital, izmir; 2Internal Medicine, Rheumatology; 3Neurology, Eskişehir Osmangazi University, Eskişehir, Turkey

Background: Behçet’s disease (BD) is a multisystem vasculitis disease and the most often neurologic manifestation of BD is headache. Transcranial Doppler ultrasonography (TCD) is a test which used for evaluating the changes in blood flow velocity developed against visual stimulation. It is not well known TCD findings in BD patients who suffered from headache.

Objectives: To evaluate the frequency of headache and to investigate cerebral reactivity by TCD in BD patients.

Methods: 113 patients with BD diagnosed based on diagnostic criteria of BD by ISG and 40 healthy individuals were included in the study. The patients with BD who had neurological involvement were not included to the study. Headache type was specified by a specialist neurologist according to International classification of headache disorders society criteria. TCD was applied to 62 patients with BD and 40 healthy individuals. TCD results were evaluated by a specialist neurologist.

Results: Headache was determined in 89 (78.8%) patients with BD. It was statistically significant compared to HC group (60%, p<0.03). 48 of 89 BD patients had tension type of headache and 33 of them had migrainous type. No significant differences were found between BD patients and HC group in terms of cerebral reactivity by TCD. Low pulsatility index for both the right side and the left side were noted in BD patients suffering from headache compared to BD patients not having headache (p<0.006, p<0.003). No significant differences were found between tension type and migrainous type of headache in terms of TCD parameters.

Conclusions: Headache is common in BD patients, but cerebral reactivity is maintained.

Acknowledgements: None
Disclosure of Interest: None declared

THU0611

HEADACHE IN BEHCET’S DISEASE AND ITS EVALUATION BY TRANSCRANIAL DOPPLER ULTRASONOGRAPHY
F. Saligü2, D. Uskudar Cansu3, U. Uzuner2, C. Korkmaz2, 1Internal Medicine, Endocrinology, Kent Hospital, izmir; 2Internal Medicine, Rheumatology; 3Neurology, Eskişehir Osmangazi University, Eskişehir, Turkey

Background: Behcet’s disease (BD) is a multisystem vasculitis disease and the most often neurologic manifestation of BD is headache. Transcranial Doppler ultrasonography (TCD) is a test which used for evaluating the changes in blood flow velocity developed against visual stimulation. It is not well known TCD findings in BD patients who suffered from headache.

Objectives: To evaluate the frequency and the types of headache and to investigate cerebral reactivity by TCD in BD patients.

Methods: 113 patients with BD diagnosed based on diagnostic criteria of BD by ISG and 40 healthy individuals were included in the study. The patients with BD...
Immune Related Adverse Events (irAEs) Associated with Checkpoint Inhibitors: 12 Cases from a Single Centre

D. Ennis, F. To, S. Jamal. Rheumatology, University of British Columbia, Vancouver, Canada

Background: Immune checkpoint inhibitors (ICI) have made a significant impact on the treatment of many advanced malignancies. There is little data on the rheumatologic complications of ICI treatments.

Objectives: We describe 12 cases of rheumatologic irAEs following ICI treatment to further characterise the spectrum of disease and treatment responses.

Methods: We report patients evaluated in a general Rheumatology outpatient clinic from 2014 to 2017. Cases were defined as those with new rheumatologic symptoms following treatment with an ICI. Alternative explanations for the presenting syndrome were excluded clinically. Clinical data was extracted by retrospective chart review.

Results: This case series includes 12 patients (6 female, 6 male) with a mean age at IRAE onset of 63.9 years (range 33–79). Multiple cancers were represented including melanoma (n=9), Hodgkin’s lymphoma (n=1), squamous cell lung cancer (n=1), and adenocarcinoma of the lung (n=1). 5/12 patients received Nivolumab, 8/12 received Pembrolizumab, and 2/9 received Ipilimumab. ICI exposure was associated with various rheumatologic irAEs including PMR-like syndromes (n=4), symmetric polyarthritides (n=6), psoriatic arthritis (n=1), oligoarthritis (n=1), and erythema nodosum (n=1). Other irAEs were also noted including vitiligo (n=1), pulmonary capillaritis (n=1), ulcerative colitis (n=1), inflammatory seborrheic keratosis and psoriasis (n=1). The mean time of onset of the irAE from the first exposure to ICI was 6.8 months (range 0–21 months). In 7 cases, rheumatologic symptoms worsened following each ICI dose. Laboratory investigations demonstrated elevated CRP in 7 cases (mean 75.6; range 3.7–290.1), RF positivity in 2 cases, weak positive ANAs in 4 cases (1:80), SSA positivity in 2 cases, and a single case where a pre-existing anti-CCP antibody was identified. Steroids were used in 11 cases at a mean starting dose of 36 mg (range 10–50 mg) by mouth daily for an average duration of 6.1 months (range 1–12 months). Other DMARDs were necessary in some cases (Hydroxychloroquine n=1; Methotrexate n=5). While 6 patients experienced rapid improvement, 4 experienced gradual improvement. Most patients achieved partial resolution of symptoms (n=6) while only 4 achieved complete resolution. Tumour response was observed in all 12 patients.

Conclusions: This case series of irAEs associated with ICI treatment suggest that symmetric polyarthritides and PMR-like syndromes are the most common rheumatologic irAEs, although the spectrum is broad. irAEs seem to develop around 6 months after first exposure, worsen with ongoing doses of ICI administration, and respond to treatment with corticosteroids. Treatment doses and durations were higher than expected for phenotype, with few patients achieving significant improvement with short courses. Those with irAEs tend to have good tumour response, despite concurrent use of immunosuppressants. MTX and HCQ appear to be safe and effective, but more experience with these and other DMARDs/biologics is required in these patients.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6009

Elevated Thyroid Stimulating Hormone as a Potential Biomarker for the Development of Rheumatic irAEs

E.M. Martin1, J. Guerrero Castillo2, A. Angeles Angeles2, G. Hernández Molina3,1.1. Immunology and Rheumatology Department; 2Pathology Department, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico

Background: The histopathological findings in IgG4-related disease (IgG4-RD) includes the presence of marked IgG4+ plasma cell infiltration seen by immunostaining and it has been used in clinical practice only as a diagnostic tool. Whether the number of IgG4+ plasma cells in tissue is associated with any clinical or serological feature of the disease has not been previously evaluated.

Objectives: To evaluate if the number of IgG4+ plasma cell infiltration is associated with any clinical or serological outcome.

Methods: We included 30 patients with biopsy proven IgG4-RD according to the Comprehensive Diagnostic Criteria for IgG4-RD who regularly attended a tertiary referral centre in Mexico City (2000–2017). We collected demographics, clinical (organ involvement, relapses and the disease activity assessed by the IgG4-RD Responder Index [IgG4-RD RI] at baseline) as well as baseline laboratory data (C3, C4, total eosinophil count, IgG4 levels). Patients were divided in three groups according to the number of IgG4+ plasma cells seen by immunostaining as follows: ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

Results: We included 30 patients, 17 (56.6%) women, mean age 53±13.9 years and median disease duration 13 months. The biopsies were from the following tissues: lacrimal gland (n=6), pancreas (n=5), orbit (n=4), kidney (n=4), lymph node (n=3), mediastinum (n=2), salivary gland (n=2) and other tissues (n=4). Eleven patients (36.6%) had ≤50 IgG4+ plasma cells/HF, 9 patients (30%) 50–100 IgG4+ plasma cells/HF and 10 (33.3%) patients>100 IgG4+ plasma cells/HF. We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

Conclusions: We included 30 patients with biopsy proven IgG4-RD according to the Comprehensive Diagnostic Criteria for IgG4-RD who regularly attended a tertiary referral centre in Mexico City (2000–2017). We collected demographics, clinical (organ involvement, relapses and the disease activity assessed by the IgG4-RD Responder Index [IgG4-RD RI] at baseline) as well as baseline laboratory data (C3, C4, total eosinophil count, IgG4 levels). Patients were divided in three groups according to the number of IgG4+ plasma cells seen by immunostaining as follows: ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

Conclusions: We included 30 patients with biopsy proven IgG4-RD according to the Comprehensive Diagnostic Criteria for IgG4-RD who regularly attended a tertiary referral centre in Mexico City (2000–2017). We collected demographics, clinical (organ involvement, relapses and the disease activity assessed by the IgG4-RD Responder Index [IgG4-RD RI] at baseline) as well as baseline laboratory data (C3, C4, total eosinophil count, IgG4 levels). Patients were divided in three groups according to the number of IgG4+ plasma cells seen by immunostaining as follows: ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

Conclusions: We included 30 patients with biopsy proven IgG4-RD according to the Comprehensive Diagnostic Criteria for IgG4-RD who regularly attended a tertiary referral centre in Mexico City (2000–2017). We collected demographics, clinical (organ involvement, relapses and the disease activity assessed by the IgG4-RD Responder Index [IgG4-RD RI] at baseline) as well as baseline laboratory data (C3, C4, total eosinophil count, IgG4 levels). Patients were divided in three groups according to the number of IgG4+ plasma cells seen by immunostaining as follows: ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.

We did not find any difference regarding age, gender, time of follow up, number of involved organs and relapses. The median basal IgG4-RD RI was 6 and 15, for the ≤50 IgG4+ plasma cells/HF, 50–100 IgG4+ plasma cells/HF, and >100 IgG4+ plasma cells/HF.