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ARTHRITIS IN PRIMARY SJÖGREN'S SYNDROME: CHARACTERISTICS, OUTCOME AND TREATMENT FROM FRENCH MULTICENTER RETROSPECTIVE STUDY

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Background: Primary Sjögren's syndrome (pSS) is a chronic inflammatory disorder characterised by diminished lacrimal and salivary gland functions. Joint involvement is reported in 20% to 60% of pSS patients, and among them one third of patients present synovitis. There is a lack of data concerning therapeutic management during pSS-associated synovitis.

Objectives: To describe the characteristics and the outcome of pSS associated arthritis and to compare the efficacy of different therapeutic regimen.

Methods: We conducted a retrospective study using Club Rhumatisme and Inflammation (CRI) and French Internal Medicine Society (SNFMI) networks. All patients with a diagnosis of primary Sjögren's Syndrome (pSS) and at least one clinical and/or echographic synovitis were included. Patients with synovitis (cases) were compared to pSS patients without synovitis (controls).

Results: 57 patients (93% women) were included with a median age of 54 years.⁴⁵⁻⁶³ Patients with synovitis had more frequently lymph node enlargement (12.3% vs. 1.8%, $p=0.007$) and a higher ESSDAI score (8^{6-12} vs. 2^{1-4} , $p<0.0001$). There was no difference concerning CRP levels, rheumatoid factor and CCP-antibodies positivity. Among 57 patients with synovitis, 101 lines of various treatments have been used during the follow-up of 40 [22.5–77] months. First line treatment consisted in steroids alone (3.5%), steroids in association (79%) with hydroxychloroquine (HCQ) (49%), methotrexate (MTX) (35%), rituximab (RTX) (5.3%) or other immunosuppressive drugs (7%). The number of complete/partial joint responses significantly increased considering the number of overall lines of treatment for MTX, HCQ and RTX: 52% for the first line, 76% for the second line and 83% for the third line ($p<0.05$), and data were similar considering each drug separately. There was no difference of efficacy between HCQ, MTX, and RTX concerning tender and swollen joint count, CRP level, ESSDAI score and steroids sparing effect at the end of each drug regimen. We performed a propensity score based analysis to determine whether HCQ, MTX, or RTX treatment was associated with better joint outcome. No difference could be shown for the joint response between three treatment regimen (MTX vs. HCQ, OR 1.55 [0.18–13.55], $p=0.69$; MTX vs. RTX, OR 5.08 [0.49–52.17], $p=0.17$; HCQ vs. RTX OR 3.28 [0.28–38.02], $p=0.34$). All 3 treatments (HCQ, MTX, and RTX) were associated with a significant reduction of ESSDAI score and a significant steroids-sparing effect.

Conclusions: pSS articular manifestations may include synovitis which could mimic rheumatoid arthritis but differ by the absence of structural damage. Even if the use of HCQ, MTX, and RTX seem to be effective for joint involvement, the best regimen remains to be determined.

Disclosure of Interest: None declared

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FRI0313

A RITUXIMAB AND BELIMUMAB COMBINATION THERAPY IN SLE PATIENTS

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Objectives: To assess the efficacy of a rituximab and belimumab combination therapy in pts with active SLE and dynamics of CD19+ B-lymphocytes count in treated pts.

Methods: The study included 7 SLE pts (1M/6F) with high (SLEDAI2K ≥ 10 – 4pts.) and moderate (SLEDAI2K < 10 – 2pts.) disease activity; out of them 1 patient had lupus nephritis, 1- vasculitis, and remaining 5 had predominantly mucocutaneous and articular manifestations of SLE. The dose of oral GCs at baseline did not exceed 20 mg/day, two pts were treated with prednisone 5 mg/day. The damage index at baseline was 0 in 3 pts, ≤ 1 in 3pts, and ≥ 1 – in 1 patient. Rituximab (RTM) was administered at 500–1000 mg, with subsequent adding of Belimumab (BLM) 3 months later at a standard dosing regimen 10 mg/kg once a month during 9mo. CD19+ B- lymphocytes counts were obtained before initiation RTM (0), and subsequently after 3, 6, 9, and 12mo. Depletion of CD19+ B- lymphocytes after RTM was assessed as the decrease of B-cell counts after 3mo $< 0.01 \times 10^9/l$, where $0 \times 10^9/l$ was categorised as complete depletion, from 0001 to $0.01 \times 10^9/l$ – partial

depletion, and $> 0.011 \times 10^9/l$ – absence of depletion. The comparison group included 20 pts receiving a single 500–2000 mg dose of RTM.

Results: 6 pts demonstrated the decrease in clinical and laboratory SLE activity, starting from 3mo of follow-up (SLEDAI-2K 0 mo–Me 10, 9; 16 3mo–Me 8, 4; 86mo–Me 4, 2; 6 9mo–Me 5, 4; 10 12mo–Me 2 2; 6) with RTM+BLM combination therapy. The oral GCs dose was reduced to 7,5 5; 10mg/day by 12mo, none of the patient required prednisone dose escalation during follow-up. There were no cases of severe infection. The damage index did not increase by 12mo. The combination therapy reduced the absolute counts of CD19+. B-cells. RTM therapy resulted in complete depletion in 2 pts, in partial depletion – in 3; in 1 patient the depletion was not documented. Addition of BLM resulted in slowing down of CD19 + B-cell repopulation (figure 1) among pts with complete and partial depletion (0mo–Me $0.11 \times 10^9/l$ [0;1;0,28], 12mo -Me $0.01 \times 10^9/l$ [0,0085; 0,025]) vs pts receiving RTM monotherapy (0mo–Me $0.1 \times 10^9/l$ [0,06;0,2], 12mo -Me $0.03 \times 10^9/l$ [0,008; 0,08]). The decrease in CD19+ B-cell counts after RTM was also documented in the patient who didn't develop depletion initially (0mo– $0.5 \times 10^9/l$, 12mo– $0.04 \times 10^9/l$). RTM and BLM combination failure, as well as failure of standard GCS and cytostatic based therapy, was documented in one patient with cutaneous, articular and haematological SLE.

Abstract FRI0313 – Figure 1. Dynamics in CD19+ B-lymphocytes in pts treated RTM and RTM+BLM combination therapy

Conclusions: Combination therapy allows to gain control over disease activity in short time, due to the effect of RTM, while added BLM provides further prolongation of the effect achieved, minimising the risk of exacerbation. This combination may be used as a method of choice in pts with severe SLE involving vital organs, and in persistent cutaneous-articular disease and high immunological activity. Of notice is the fact, that use of RTM and BLM combination allowed to manage all pts on low and medium doses of GCs starting from RTM and BLM initiation and during the entire follow-up, thereby reducing the risk of irreversible organ damage. In these patients there were no signs of infection.

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FRI0314

RISK OF OPHTHALMOLOGIC COMPLICATIONS AS A RESULT OF HYDROXYCHLOROQUINE THERAPY

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Background: Hydroxychloroquine is a drug therapy licensed for patients with cutaneous and systemic lupus. A major side effect is maculopathy that can result in permanent visual loss. Often, symptoms are preceded by signs, and screening for preclinical retinopathy can decrease incidence and development of 'bullseye retinopathy'.^{1,2} More recent high quality studies suggest cases of confirmed toxicity in 1% of patients at 5–7 years and therefore documentation of monitoring is imperative.^{3,4}

Objectives: In accordance with the British Rheumatology Society guidelines 2008 an audit was carried out in March 2017 to assess whether patients on hydroxychloroquine were being monitored for maculopathy while on therapy.

Methods: The sample group comprised of 76 patients who were on active hydroxychloroquine treatment for SLE, chosen through randomised computer generated numbers. Electronic notes for individual patients over the last 12 months was reviewed for mention of ophthalmologic monitoring, indicating the clinician is aware and surveilling possible signs of toxicity.