(78.8%); Erythema marginatum in 7 (21.2%); Sydenham chorea, 4 (12.1%); Subcutaneous nodules, 2 (6.1%), respectively. And minor criteria were: fever, 27 (81.8%); first degree heart block, 7 (21.2%); elevated inflammatory markers (ESR, CRP), 30 (90.9%). ARF patients were treated with antimicrobial agent therapy 33 (100%); NSAIDs 24 (72.7%); and glucocorticoids therapy 15 (45.4%). All ARF patients were prescribed with antimicrobial agent prophylaxis.

On the other hand, the mean age of PSRA was 8.0 years (3-14 years), and female/male ratio was 17/14. Three patients (9.4%) had monoarthritis, 15 patients (46.9%) had oligoarthritis, and 14 patients (43.6%) had polyarthritis. Two patients had arthritis and enthesitis. And fever in 24 (75.0%) and Elevated inflammatory markers in 29 (90.6%). PSRA patients were treated with antimicrobial agent therapy 25 (78.1%); NSAIDs 27 (84.4%); and glucocorticoids therapy 3 (9.4%). During the follow up, there was no patient with carditis. 18 (56.3%) patients with PSRA were prescribed with antimicrobial agent prophylaxis.

Conclusion: In this study, ARF is rare in the Japanese pediatric population, but ARF has not yet disappeared. We observed high incidence of arthritis, carditis and erythema marginatum. No PSRA case was complicated with carditis. General pediatrician need to have updated information about ARF and PSRA even in industrialized countries.

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SAT0517 MANAGEMENT OF RISK OF VARICELLA INFECTION IN IMMUNOCOMPROMISED CHILDREN: WHAT IS THE EVIDENCE?

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Background: Varicella-naïve children on methotrexate are at risk of severe infection if they encounter varicella. Current guidance advises that children on low-dose methotrexate can safely receive live vaccines¹, but management of children on higher doses or combination immunosuppression is challenging as there is no consensus about their management. Acyclovir and varicella-zoster immune globulin (VZIG) are commonly used as post-exposure prophylaxis (PEP).

Objectives: Assess the evidence for use of acyclovir and/or VZIG as PEP in the management of varicella exposure in susceptible children taking methotrexate.

Methods: A literature search using PubMed, the Cochrane Library and EMBASE was conducted from November to December 2017, using the terms methotrexate, immunocompromised, varicella, child, prophylaxis, acyclovir, VZIG and their variations. Only full papers, in English language, studying children were analysed (63 abstracts read for relevance, 28 papers obtained, 11 papers included).

Results: There have been no randomised controlled trials (RCTs) analysing the effectiveness of acyclovir and/or VZIG as PEP in immunocompromised children. The studies that do exist (see table for key publications) are small and uncontrolled and have largely been carried out in oncology rather than rheumatology patients. While they suggest

that acyclovir and VZIG are effective at reducing historical infection rates of >70%¹, a significant proportion of recipients still get varicella.

Conclusion: There is only level 3 evidence for the use of acyclovir and/or VZIG as PEP in susceptible children on methotrexate. The literature indicates acyclovir is more effective, but this is a grade 3 recommendation only. A RCT to compare the effectiveness and acceptability of VZIG and acyclovir is needed, however the difficulty of randomising a cohort of similarly immunocompromised patients should not be underestimated.

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SAT0518

READINESS FOR TRANSITION – CROATIAN VERSION AND PILOT EVALUATION OF THE TRANSITION READINESS ASSESSMENT QUESTIONNAIRE (TRAQ) IN RHEUMATOLOGIC PATIENTS

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Background: Rheumatic diseases of childhood extend to adulthood as an active disease in 30-70% of patients, which is the reason for requiring transition of rheumatologic care into adulthood. Transition should be individualized based on patient's readiness, and good transition readiness analysis tools should be available at the time of transition.

Objectives: As systematic review of the available assessment tools for transitional readiness in adolescents with chronic diseases has shown that only the Transition Readiness Assessment Questionnaire (TRAQ) has proven reliability in its key measurement components¹, we have decided to use the TRAQ² in pediatric rheumatology patients.

Methods: English version of TRAQ was translated to Croatian, afterwards a back-translation to English was done. Due to difference in the insurance policy in Croatia (health care is free for children under 18 years of age), question 9 was modified into: "Are you aware of the fact that after 18 years of age you have to start paying for the additional health insurance?"

A pilot study was performed in order to validate translated TRAQ by applying questionnaire to pediatric rheumatology patients at the time of transition.

Results: A total of 41 patients at the median age of 18.25 years (range 17.8-21.1 years) were enrolled, 28 female and 13 male patients. Most of

Authors	No. of Patients & VZV Status	Cause of Immunosuppression	Treatment	Outcomes
Evans et al (1980) ²	102 immunosuppressed children, 80 of whom were known to be seronegative for VZ IgG antibodies	Variable	Zoster immune globulin (ZIG) as a single dose - up to 1 year, 100 mg; 1-5 years, 250 mg; 6-10 years, 500 mg; 11-14 years, 750 mg; 15-16 years, 1000 mg	24/80 became infected; 17 with symptoms
Zaia et al (1983) ³	164 immunocompromised children	Variable 131: malignancy 30: other immunosuppressive treatment 3: primary immunodeficiency	81 given VZIG 83 given ZIG Dose: 1.25 ml/10 kg (max dose, 6.25 ml), given within 96 hours of exposure	VZIG: 49/81 became infected ZIG: 57/83 became infected Varicella pneumonia occurred in 3 cases in each group
Shinjoh et al (2009) ⁴	65 immunocompromised children (some with a history of varicella); 76 immunocompetent children; 11 immunocompetent controls	Variable	Oral acyclovir (10 mg/kg/dose; 400 mg max dose; 4 times daily). Minimum of 7 days treatment, starting from 7 days after exposure	2/65 immunocompromised children developed varicella. 1/76 immunocompetent children developed varicella. 2/11 controls developed varicella