LN was noted in any of the 7 pts. 5 pts are followed by Rheumatology for extrarenal SLE; no extrarenal manifestations are documented in the other 2. Data on SLE Disease Activity pre and post bela were available and scored in 3/5 pts using the SLEDAI-2KG which accounts for clinical and laboratory manifestations, as well as steroid use (Fig. 2). Mean ds-DNA pre and post bela was 133 ± 178 UI/mL and 58 ± 72 UI/mL; C3 89 ± 31 mg/dL pre and 91 ± 21 mg/dL post; C4 35 ± 15 mg/dL pre and 38 ± 7 mg/dL post.

Conclusion: Bela in LN KT recipients may decrease extrarenal manifestations, attenuate CNI toxicity and stabilize allograft function, providing a better alternative to CNI regimens. Furthermore, these data suggest that bela may be a therapeutic option in SLE.

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AB0462 IMMUNIZATION TO RITUXIMAB IS MORE FREQUENT IN AUTOIMMUNE SYSTEMIC AUTOIMMUNE DISEASES THAN IN RHEUMATOID ARTHRITIS AND MAY BE MANAGED BY SWITCHING FROM RITUXIMAB TO OFATUMUMAB

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Background: The most widely used B cell targeted therapies in autoimmune diseases (AID) is Rituximab (RTX), a murine chimeric monoclonal antibody. Among RTX's side effects, immunization and anti-drug antibodies to RTX (RTX-ADA) production have been reported but their consequences are poorly described. The immunization rate against RTX in rheumatoid arthritis (RA) is 2.7–9.2% and it seems to be higher in other sAID although data is lacking.

Objectives: We aimed to evaluate the frequency, consequences and predictive factors of RTX-ADA in RA and sAID, as well as the use of an alternative B-cell targeted therapy, ofatumumab (OFA) in case of RTX-ADA.

Methods: All patients with RA or sAID treated with RTX from 2012 to 2017 in our tertiary reference centre for sAID were retrospectively studied. Patients who were tested for RTX-ADA were identified. Clinical and biological characteristics of RTX immunized patients were compared to those of non-immunized patients. For patients treated with OFA, clinical and biological efficacy was obtained before and after treatment.

Results: 199 patients were treated with RTX (RA: 124, sAID: 75 including 38 primary Sjögren's Syndrome (pSS), 15 systemic lupus erythematosus, 7 myositis, 6 overlap syndrome, 5 ANCA-associated vasculitides and 4 other sAID). Among the 62/199 (31.1%) tested for RTX-ADA, 14 were positive: 3/35 RA (8.6%) and 11/27 (40.7%) other sAID, ($p=0.005$). Among the whole RTX-treated patients, the frequency of RTX-ADA was 2.4% and 14.7% ($p=0.003$) in RA and in other sAID, respectively. Most of the immunized patients experienced delayed infusion reactions (11/14 [78.5%]). Delayed reactions were observed within the first 15 days after the infusion, and after a median 2 cycles [range; 1–2]. They were mainly rash (72.7%), fever (54.5) and/or abdominal pain (36.3%). Predictive factors of immunization were a sAID compared to RA (40.7% vs 8.6%,

$p=0.005$), and young age (50.5 vs 61.5 years, $p=0.003$). Neither hypergammaglobulinemia, rheumatoid factor, disease activity, nor associated immunosuppressive therapy were associated with RTX-ADA. Among 23 tested patients with SLE or pSS, anti-SSA antibodies tended to be more frequent in immunized patients than non immunized (9/10 (90.0%) vs. 8/13 (61.5%), $p=0.18$). Three pSS patients immunized against RTX were treated with OFA because of associated cryoglobulinemic vasculitis or MALT lymphoma. All 3 experienced complete remission of their disease. Relapse occurred in 2 patients, one with MALT lymphoma after 14 months, one with cryoglobulinemic vasculitis after 10 months and were retreated successfully with OFA. No adverse events were reported.

Conclusion: Our results show that immunization against RTX is more frequent in other sAID than in RA. Testing for ADA must be performed in patients with infusion reactions. Patients immunized to RTX might be treated efficiently with OFA, which should be further evaluated in sAID.

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AB0463 BELIMUMAB IV EFFECT IN GLUCOCORTICOID TREATMENT IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS

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Background: Systemic lupus erythematosus (SLE) is an autoimmune chronic disease produced by aberrant immunological response that consequently, causes a widespread organic damage. Treatment leads to regulating this disrupted immunological response. As a result, in 2011 Belimumab was approved for adults patients diagnosed with SLE, what is a monoclonal human antibody whose target is a B-lymphocyte stimulator (BLyS), a protein involved in the disease pathogeny.

Objectives: To evaluate the glucocorticosteroid dose variation in adult patients with systemic lupus erythematosus during Belimumab IV treatment.

Methods: Retrospective, observational study that includes patients diagnosed with SLE according to SLICC 2012 criteria, who are treated with Belimumab IV. Treatment has been administrated as an initial dose: 10 mg/kg every 14 days and then, a maintenance dose: 10 mg/kg every 28 days. Data from serological profile, clinical manifestations at diagnoses and at the onset of treatment, existence of comorbidities or other diseases, concomitant therapy directed to the main disease or to the complications that came from the disease, non administration causes and definitive treatment discontinuation were collected from July 2012 until December 2018.

Results: A total of 19 patients (94.74% women) with 28 years old (Q1 14, Q3 31.82) as a median age at diagnosis and 11 (Q1 6.5, Q3 20) years since disease diagnosis were included. Follow up mean was 29 (Q1 7.5, Q3 37) months.

Regards to concomitant therapies, 5 patients (26.31%) were treated with Azathioprine and 3 patients with Methotrexate (15.79%). At the onset of biological therapy, 17 patients were treated with glucocorticoids, at a dose of 10 mg (Q1 9.38, Q3 10.63). At the end of follow up, 18 patients (94.73%) were treated with corticoid and the mean dose was 8.75 mg (Q1 8.75, Q3 8.75).

Table 1. Characteristics of patients on bela.

ID	Age at SLE dx	Race	LN class	Time to KT (yrs)	Type KT	Induction	Reason for conversion	Immunosuppressive regimen before conversion
A	16	Black	IV, VI	13	DDKT	ATG	Non-adherence	TAC, MMF
B	30	Asian		2	LRKT	ATG	Mod IFTA & Arteriosclerosis	TAC, MPA, PRED
C	18	White	IV, V	23	DDKT	ATG	Cortical necrosis	CYC, MMF, PRED
D	19	Black	V	9	LUKT	ATG	CNI side effects	TAC, MPA, PRED
E	22	Asian		5	LRKT	ATG	CNI side effects	TAC, MMF, PRED
F	18	Black	V	17	DDKT	Alentuzumab	CNI side effects	TAC, MMF, PRED
G	25	White (Hispanic)	III, IV	23	DDKT	Basiliximab	TMA (biopsy)	TAC, MPA, PRED

We observed a mean corticoid dose reduction of 4.02 mg (Q1 2.5, Q3 5). Dose was not modified in 4 patients after the beginning of Belimumab IV. As exceptions, in 1 patient we added corticoids to treatment (dose of 5 mg/day) and in another one we doubled corticoid dose, until a maximum dose of 20 mg/day.

Belimumab treatment was definitive discontinued in 5 patients because of peripheral venous insufficiency, pregnancy, itchy skin lesions, uncertain drug allergy and primary pulmonary hypertension.

Conclusion: As we observed, an important percentage of patients (in our sample close to 90%) take usually corticoids, with the clinical consequences and development of comorbidities in a long time and adverse events related to this therapy. Diary dose is reduced in 57.9% of our patients, even in those patients who have discontinued Belimumab treatment, in which we observed a dose reduction too.

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AB0464 EFFECTIVENESS AND SAFETY OF ABATACEPT FOR 24 MONTHS FOR TREATING PATIENTS WITH PRIMARY SJÖGREN'S SYNDROME (PSS)

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Introduction: Primary Sjögren's syndrome (SSp) is a systemic autoimmune disease concerning the exocrine glands and internal organs. Therapeutic options mainly include symptomatic and supportive measures, whereas traditional immunosuppressive drugs have not presented efficacy in randomized trials. Abatacept is a T-cell co-stimulation modulator and there are evidences that this drug may be effective for treating Pss.

Objectives: The objective of this trial was to evaluate effectiveness and safety of abatacept for 24 months in the treatment of pSS.

Methods: Observational prospective study for 24 months. It was included 11 patients that filled the American-European Consensus criteria (2002). Patients received abatacept according the weight < than 60 kilos (500mg), 60 kilos to 100 kilos (750 mg) per month for 24 months. It was evaluated Sjögren's syndrome disease activity index (ESSDAI), salivary flow with no stimulation for 15 minutes, Schimer's ophthalmologic evaluation tests, Ocular Staining Score (OSS) e Break up time, quality of life by Medical Outcome Survey Short Form 36 (SF-36) and fatigue by FACIT Fatigue - The Functional Assessment of Chronic Illness Therapy. For statistical analysis was used the Wilcoxon's test for related samples and test T of Student to paired samples. The significance level of 5% was adopted and analyzes were accomplished in the R program (version 3.5.1).

Results: This study was constituted from 11 women between the ages 25 to 81 years (average: 53.73 ± 15.07 years), being the majority afro-descendant women (54.5%). Of this total, 90.9% presented positive anti-nuclear antibody (ANA), 81.8% positive anti/SSA, and 90.9% positive rheumatoid factor. In relation to ESSDAI, 81.8% of the participants presented scores greater than 5. There was a statistically significant reduction in the ESSDAI IC 2.99 [-0.49; 7.99] (p = 0.013). Between the sub items of the ESSDAI, the ones that demonstrated the greatest modifications were articular and glandular. There was a significant increase in the salivary flow of the participants (dif = -0.90; IC-95%: -1.50; -0.50] after 24 months of treatment. There was no statistical difference between the beginning and after 24 months of treatment in the different evaluations, Schimer's ophthalmologic right eye IC 2.26 [-3.50; 12.5] p=0.423, Break up time OD 0.50 [-1.00; 2.49] p=0.307, OSS right eye IC: 0.50 [-2.50; 5.50] p=0.721. In the SF36 only in the Limitation for Emotional Aspects sub scale reported significant improvement (dif = 36.4; IC95%: -67.1; -5.57; p = 0.025), and FACIT presented no evidences of significant changes between pre and post treatment p = 0.356.

Conclusion: The study demonstrates limitations due to the few number of patients included and for being an open study not controlled, but we observed a statistically significant reduction in the ESSDAI, increase in the salivary flow and in the sub scale Limitation for Emotional Aspects of the SF36, indicating a positive effect in the disease.

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AB0465 EFFICACY AND SAFETY OF IGURATIMOD IN PATIENTS WITH PRIMARY SJÖGREN SYNDROME: A FOLLOW-UP STUDY

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Background: Primary Sjögren syndrome (pSS) is a chronic autoimmune disorder affecting 0.2–3% of the population. However, there are currently no effective systemic therapies. Anti-Ro, anti-La and rheumatoid factor(RF) as well as hyper γ -globulinaemia indicate a degree of B cell hyperactivity. In the recent ten years, iguratimod (T-614) has been used to treat RA as a novel immunomodulatory, which functions by suppressing the production of some inflammatory cytokines, as well as reducing immunoglobulin production by acting directly on human B lymphocytes without affecting B lymphocyte proliferation.

Objectives: We evaluated the effectiveness and safety of iguratimod on pSS patients in this follow up study.

Methods: A total of 21 pSS patients without severe systemic damage needing corticosteroid were recruited to receive iguratimod 25mg Bid for 12 weeks.

Results: Among them, 1 patient and 2 patients withdrew because of kidney dysfunction and ineffectiveness. For those 18 patients who finished the follow up, 94.4% were females and average age were 46.5±13.8 year-old with median disease duration of 22.0 (9.8, 58.5) months. Compared with baseline, ESSDAI score, hyperglobulinaemia and ESR was significant decreased after iguratimod treatment (Table). Two of the 18 patients presented with decreased white blood cell count. This side effect ameliorated in one patient after tapering the dose to 25mg Qd and in another patient after 2 weeks without any intervention.

Table. Effectiveness of iguratimod in pSS

	Baseline (B)	12w	P value (vs. B)	24w	P value (vs.12W)	P value (vs. B)
IgG	23.19±5.50	20.19±5.21	0.009	18.52±4.64	0.064	0.001
IgM	1.27±0.39	0.98±0.42	0.000	0.97±0.39	0.908	0.001
IgA	4.16±1.30	3.51±1.41	0.000	3.29±1.07	0.045	0.000
ESR	26.69	19.62	0.015	15.57	0.929	0.043
	±17.68	±10.89		±11.28		
ESSDAI	4.5±2.5	3.0±2.4	0.001	2.08±1.44	0.237	0.004

Conclusion: This is the first follow study of iguratimod in pSS to show benefit with good tolerance.

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