scored using the JDM severity score tool. The histo-pathologists' overall severity score (VAS) varied from to 1 to 9/10; the highest scores were observed in the two patients who died.
Conclusion: In the present series of patients with JDM, TIF-1-γ Ab-associated-clinical phenotypes and ethnicities are more heterogeneous than previously reported. TIF-1-γ Ab is associated with a high mortality rate in a subset of patients.

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AB0936 A NATIONAL SURVEY OF CLINICAL PRACTICE OF CORTICOSTEROID USE IN NEWLY DIAGNOSED OR FLARING CASES OF JUVENILE IDIOPATHIC ARTHRITIS ACROSS THE UK

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Background: Corticosteroids (CS) are widely used for rapid-action or induction treatment in children and young people (CYP) with juvenile idiopathic arthritis (JIA). Given a lack of evidence base on CS induction regimen for CYP with JIA, and since criteria for choosing CS are based on healthcare professional (HCP) preference, further research is needed (1).
Objectives: To establish the opinions of HCPs current practice regarding the clinical criteria for commencing CS treatment
Methods: A national electronic survey was undertaken among HCPs across the UK as part of the Steroid Induction Regimen for Juvenile Idiopathic Arthritis (SIRJIA) study.
Results: A total of 39 (24%) responses were received from 162 HCPs. These included 22 (56%) NHS consultants, five (13%) grid trainees, eight (21%) clinical nurse specialists and four other HCPs (10%).
The most common treatments in CYPs with newly diagnosed JIA or a disease flare were intra-articular (IA) CS or a combination of DMARDs and IAS (except for systemic JIA and oligoarticular JIA). The majority of HCPs 17 would treat new and flaring CYP the same in terms of a CS remission induction regime, with 53% choosing a different regime or not answering.
The key criteria that HCPs used for commencing CS and choosing the route of administration were rapid induction of remission (31 (89%)), high disease activity (31 (89%)), severity of systemic JIA (30 (86%)) and level of inflammation (28 (80%)) Table 1. The number one determinant of route of administration of CS was disease severity followed by disease subtype.
The majority of HCPs (52-72% depending on role) would consider entering CYP with JIA into a trial randomising to the various modes of administration.

Table 1:

Reasons of CS Choice	Number N=39	Percentage%
High Disease Activity	35	89.7
Rapid induction of remission	34	87.2
Severity of Systemic JIA	34	87.2
Level of inflammation	32	82.5
Severe Uveitis	30	76.9
JIA subtype	27	68.2
Targeting Specific Joints	26	66.7
Level of Disability	18	46.2
Level of pain	16	41.0
Long-standing Disease	11	28.1
Patient reluctance to take DMARDS	8	20.5

Conclusion: The results from this national survey of clinical practice showed varying practices in the management of new CYP with JIA and those that are flaring. The majority of HCPs who completed this survey, indicated that they would be prepared to consider entering CYP into a trial that randomised to the four CS delivery methods.

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AB0937 IDENTIFYING THE PRIMARY OUTCOME MEASURE AND PROTOCOL COMPONENTS FOR A PROSPECTIVE FEASIBILITY STUDY OF CORTICOSTEROID REGIMENS FOR CHILDREN AND YOUNG PEOPLE WITH JUVENILE IDIOPATHIC ARTHRITIS USING CONSENSUS METHODS WITH YOUNG PEOPLE, FAMILIES AND PROFESSIONALS

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Background: Juvenile idiopathic arthritis (JIA) is an umbrella term for seven relapsing-remitting inflammatory conditions in children and young people (CYP). Early, intensive treatment can prevent long-term damage; however, established drugs exhibit a delayed response, prompting the need for rapid-onset treatment in the form of corticosteroids. Given a lack of consensus as to which corticosteroid induction regimen should be used for CYP with JIA, a feasibility trial of different regimens is needed.