Figure 1

Figure 1

Nonetheless, two months later, due to the persisting arthritis activity, anti TNF therapy was started. Etanercept at the dose of 0,8 mcg/week was found to be effective and safe, allowing the patient to walk again. Since the therapy onset, no severe adverse reaction was observed.

Conclusion: This is the first case of a kid with HI and poliartthritis treated with IACI and anti-TNF agent in combination with MTX. This clinical case shows the efficacy of IACI as a safe and powerful mean, with fast clinical response, in the treatment of arthritis in those patients. Furthermore, we observe the efficacy and safety of anti-TNF agents as baseline therapy for arthritis in patients with HI.

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AB0939 NAILFOLD CAPILLAROSCOPY IN JUVENILE DERMATOMYOSITIS. DESCRIPTION OF ABNORMALITIES IN A SERIES OF PATIENTS

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Background: Juvenile dermatomyositis (JDM) is characterized by the presence of microangiopathy which can be assessed by nailfold capillaroscopy (NFC), a simple and noninvasive imaging technique. Morphological abnormalities in scleroderma NFC are well described, but it is known that they may be present in other autoimmune diseases, such as JDM.

Objectives: To describe the capillary morphological abnormalities assessed by NFC in a series of patients diagnosed with JDM in contrast with patients diagnosed with juvenile idiopathic arthritis (JIA).

Methods: A cross-sectional descriptive study in which 34 patients were recruited sequentially and randomly, 15 with JDM and 19 with JIA, from the Rheumatology department of Niño Jesús Hospital between September-November (2018). Demographic, clinical, analytical data, presence and subtype of calcinosis, active treatment, HAQ, patient and physician global assessment (PGA), cutaneous assessment tool (CAT) and manual muscle testing (MMT8) validated for JDM were collected. One observer performed blindly, both for clinic and diagnosis, a NFC initially using a videodermatoscope in order to obtain a wide view of the vascular bed and then with a videocapillaroscope (x500), which recorded 2-4 images per finger (except thumbs) to be analyzed far ahead. The presence of a decreased nailfold capillary density (NCD, capillary n°/mm≤6), architectural derangement (disorganization), neoangiogenesis, giant capillaries (ø>50µm, pathological if ≥1), enlarged loops (ø20-50µm) and microhaemorrhages, both pathological present in ≥2 fingers were evaluated. Neovascular pattern was defined as the sum of NCD, disorganization and neoangiogenesis with frequent haemorrhages and giants (active and late scleroderma pattern).

Results: The descriptive analysis of the main variables is shown in table1. Patients with **JIA:** all received active treatment, 95% MTX (33% concomitant with anti-TNF, 1 TCZ and 16% CE) and 1 anti-TNF. 26% active uveitis. Two patients presented morphological abnormalities: 1 neoangiogenesis and another enlarged loops. Patients with **JDM:** 73% received MTX (18% concomitant with CE, 73%IGs and 1 RTX). Three patients had active calcinosis: 2 mixed (circumscribed and cutis) and 1 calcinosis cutis. 2 had previous calcinosis (both circumscribed). 87% presented for the first-time weakness but none had current weakness (MMT8 40). 67% presented morphological abnormalities: NCD 33%, disorganization 40%, neoangiogenesis 53%, enlarged loops 27%, giants 20% and microhaemorrhages 13%. All patients with calcinosis (active or previous) presented disorganization and neoangiogenesis, NCD 80%, giants 60%, enlarged loops and microhaemorrhages 40%. 50% of patients with JDM had a neovascular pattern, of which 80% had a previous or current history of calcinosis.

Conclusion: Patients with JDM presented more abnormalities in NFC compared to patients with JIA. Neovascular pattern was observed in half of patients, who have previous or current history of calcinosis. Consequently, NFC could be a useful imaging technique in routine clinical practice to evaluate skin activity in patients with JDM.

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Abstract AB0939 TABLE 1. DEMOGRAPHIC, CLINICAL AND ANALYTICAL CHARACTERISTICS

Sex%	♀ 63 ♂ 38
Age (yr)	11
Disease duration (mn)	57
ESR/CRP	7/0.3
Patient/physician global assessment (PGA)	0/2
HAQ	0.14
Initial/current CAT BM	3/0
CPK	101
LDH	261
Initial/current MMT8	35/40

Disclosure of Interests: None declared

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AB0940 OBESITY AND NUMBER OF ACTIVE JOINTS AT TUMOR NECROSIS FACTOR-INHIBITOR START ARE ASSOCIATED WITH SHORTER REMISSION DURATION AFTER WITHDRAWAL IN PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS: PRELIMINARY RESULTS FROM A MONOCENTRIC COHORT

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Background: No recommendations on appropriate withdrawal of tumor necrosis factor-inhibitors (TNFi), once remission status has been achieved