(76.4% versus 58.4%, $p = 0.001$), although sensitivities were similar at both times. EULAR/ACR criteria score $\geq 10$ exhibited greater sensitivity than ACR 1997 (57% versus 70.5%, $p = 0.001$) at first visit, but comparable at 1-year, whereas specificity was lower at first visit (67.4% versus 83.2%, $p = 0.004$) and 1-year (58.4% versus 76.4%, $p = 0.002$). A EULAR/ACR score $\geq 13$ against a score $\geq 10$, resulted in higher specificity, positive predictive value, and cut-off point accuracy. Compared to SLICC, a EULAR/ACR score $\geq 13$ resulted in lower sensitivity at first visit (76.2% versus 89.3%, $p = 0.001$) and 1-year (91% versus 97.5%, $p < 0.008$), but similar specificities at both periods. When compared to ACR 1997, a EULAR/ACR total score $\geq 13$, resulted in no differences in sensitivity and specificity at both times.

**Conclusion:** In this cSLE population, SLICC criteria performed best at first visit and 1-year-follow-up. The adoption of a EULAR/ACR total score $\geq 13$, against the initially proposed $\geq 10$ score, was most appropriate to classify cSLE in our study. Further studies are necessary to address if SLICC might allow cSLE classification earlier in disease course and be more inclusive of cSLE subjects for clinical studies.

**REFERENCES**


**Disclosure of Interests:** None declared


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**AB0970**

**LONG-TERM FOLLOW-UP OF PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS IN A MEXICAN CENTER**

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**Background:** JIA comprises an heterogeneous group of diseases characterized by chronic arthritis, of unknown etiology, and onset age before 16. (1) Juvenile Idiopathic Arthritis(1) is the most common chronic rheumatic disease in children, being an important cause of disability, affecting quality of life (2). There are several subtypes of the disease, despite olioarticular course has been described as the most frequently seen, up to 50% of JIA cases presented a polyarticular disease (4-3).

Data suggest that patients who receive early therapeutic intervention are more likely to reach clinical remission. In a systematic review, Wallace’s criteria were used to determine drug remission and inactive disease. They reported 7% and 47% of patients reached remission at 1.5 and 10 years, respectively. Oligoarticular patients had a shorter time to remission, while polyarticular positive rheumatoid factor were the least likely to achieve it (5).

Mexico belongs to a group of developing countries where there is limited information about incidence, prevalence, clinical features, age and time to diagnosis, treatment, and remission of JIA patients.

**Objectives:** The aim of the study is to describe demographics, clinical data and long-term follow-up of a cohort of juvenile idiopathic arthritis patients in a Mexican center.

**Methods:** The study design was observational with no intervention, ambispective, among patients with JIA, according to ILAR criteria of pediatric rheumatology clinic from University Hospital “Dr. José Eleuterio González” over a 2-year period (2016-2018). Medical records of patients were retrospectively reviewed and collected information as demographics, age at diagnosis, disease activity, joints involved, treatment, adverse events, clinical inactivity and remission.

**Disclosure of Interests:** None declared


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**AB0971**

**A CASE OF PEDIATRIC IDIOPATHIC CALCINOSIS**

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**Background:** Calcinosis includes a rare group of disorders characterized by abnormal intracutaneous, subcutaneous, fascial or intramuscular calcium deposits. Idiopathic calcinosis is diagnosed after the exclusion of secondary forms related to trauma, abnormal calcium/phosphorus metabolic disorders, inflammatory processes, neoplasms, connective tissue diseases or renal insufficiency. There are very few cases reported, especially in childhood.

**Objectives:** We report the case of idiopathic calcinosis cuts in a young girl.

**Methods:** A 15-year-old female presented an abrupt onset of 2 painful swollen lesions on the left trochanteric region and over the posterior side

Figure 1

Time to remission by JIA subtype

Time in months

Fraction of patients with inactive disease

0.00 0.20 0.40 0.60 0.80 1.00

80 90 100

0.0 0.2 0.4 0.6 0.8 1.0

Figure 1
of her right elbow. The patient denied any trauma or associated symp-
toms such as muscle weakness or joint stiffness. On physical examina-
tion, a large hard mass was present over her left trochanteric region, with
hyperemic skin, and a similar one was palpable over her right
elbow.

Results: Radiographs of the two sites showed well-defined calcified
masses, one (9x5 cm) over the trochanteric region, and the other (3x2)
cm over the posterior aspect of the distal end of the humerus extending
up to the elbow. MRI confirmed the presence of calcified intramuscular
lesions (Figure 1). Serologic evaluation showed increased levels of CRP
and ESR, while autoimmune screening was negative. Calcium/phosphorus
metabolism, creatinine kinase, aldolase and ferritin levels were within the
normal limits. Therefore, a clinical diagnosis of idiopathic calcinosis was
made. After 3 months, the lesion on the elbow had spontaneously reab-
sorbed, while the other one kept on growing, with 3-4 episodes per
month of febrile painful swelling. A CT-guided biopsy was then performed,
confirming the diagnosis of calcinosis. No infectious causes were
detected. One year later, since there was no local amelioration, the
lesion was surgically removed with apparent complete local remission.
No other new lesions were detected during the 3 months follow-up period.

Conclusion: Idiopathic calcinosis is very rare and no specific medical
therapies are available. In our patient no causative factors were identified
and thus the diagnosis of idiopathic calcinosis was made. Prognosis
seems to be variable, since one lesion resolved spontaneously while the
other needed surgical excision.

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ARTEFACTUAL SKIN LESIONS: A TRAP FOR RHEUMATOLOGISTS
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Background: Dermatitis artefacta (DA) refers to deliberate and conscious
self-inflicted skin lesions to satisfy an unconscious psychological or
emotional need. It is an unusual condition often described in women,
and rarely reported in children. The disorder is often misdiagnosed and
needs to be distinguished from organic illness, Munchausen’s by proxy
syndrome, and from illicit, nontherapeutic drugs or overdose of
medications.

Objectives: We report three paediatric cases with a long medical history
characterized by many laboratory and radiological exams, and mistaken
etiologies.

Methods: Case 1. An 11-year-old female was referred to our Rheumatol-
ogy Department for a second opinion about a suspicion of Behcet’s dis-
ease based on her cutaneous manifestations. Clinical examination was
unremarkable except for bluish ecchymoses, and linear cutaneous abra-
sions and scars located in accessible areas of her skin (Figure 1, Figure
2 and Figure 3). Extensive laboratory tests and radiological exams were
normal.

Case 2. A 14-year-old female was admitted to our pediatric hospital
for a 1 month history of fever, malaise and multiple purpuric lesions.
The patient referred a 3 year history of similar recurrent episodes
characterized by abrupt onset of fever, arthralgia and purpuric lesions
for which she already received the diagnosis of urticarial vasculitis.
The girl was in good general conditions, without fever. Violaceous
ecchymotic lesions were evident on her left forearm. Exhaustive labora-
tory tests, chest X-ray, and abdomen ultrasound were within normal
limits.

Case 3. A 14-year-old female was referred to our Pediatric Rheumatology
department for a 6 month history of musculoskeletal pain, recurrent
shoulder and hip dislocations, and spontaneous ecchymosis on her neck
and face. Except for joint hypermobility (Beighton score 7/9), physical
examination was normal. At a careful orthopedic evaluation and after
shoulder and hip imaging the history of dislocations appeared to be
inconsistent. Blood and radiologic tests, cardiological and genetic evalua-
tions for Ehler-Danlos syndrome were negative.

Results: In Case 1, dermatitis artefacta was suspected and the patient
was referred to our mental health colleagues that confirmed a severe
psychological stress in a basal condition of psychiatric disorder. In Case
2, an in-depth psychological evaluation highlighted a depressive status for
personal and familiar suffering. The patient was therefore referred to our
mental health department for assessment and management. In Case 3,
eventually a psychiatric interview oriented the diagnosis to a major
depressive disorder.

Conclusion: DA is a rare condition that should be evaluated in the differ-
e ntial diagnosis, in the presence of unexplained cutaneous lesions without
an apparent identifiable cause. Association with various psychological dis-
turbances is the mainstay for this diagnosis, and a careful psychiatric his-
tory represents the essential diagnostic key to identify this disorder.

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Abstract AB0972 Figure 1