syndrome n= 7 (17.1%), SAVI syndrome n=3 (7.3%), CRMO n=4 (9.8%), PFAPA n=2 (4.9%), APLAID n=1 (2.4%), Stickler syndrome n=1 (2.4%), and 3 unknown AIDs with genetic test negative n=3 (7.3%). Current treatment is variable among patients, 6 (15.8%) are taking disease-modifying antirheumatic drugs (DMARDs), 9 (23.7%) Colchicine, 8 (21.1%) Anakinra, 13 anti-TNF therapy (34.2%), 1 (2.6%) Ruxolitinib and 1 (2.6%) Abatacept. Only 6 patients were receiving corticoids with mean prednisone dose of 7.5 mg/day. The global ADDI mean score was 2.3 ± 2.2 . Regarding the eight different items included in the item, musculoskeletal domain shown the highest score with 1.02, followed by the ocular domain with 0.42. The patient with APLAID syndrome had the highest score of 6 followed by BLAU syndrome with 4.71. FMF has the lowest score with 0.83. Laboratory test results were mean ESR 27.2 ± 26.7 mm/h, CRP 0.7 ± 1.3 mg/dl, AP 13.9 ± 18.6 mg/L. Proteinuria was present in 2 patients with mean 286.5 ± 246.1 mg/g. EM and ML applied ADDI in 5-10 minutes average.

Conclusion: ADDI is a feasible index suitable to measure damage in a single patient. Despite it was performed to the four most common AIDs it could be applied to other diseases. In our cohort the mean ADDI index was low and musculoskeletal item has the highest score. This result could be explained by the tight control of the disease and successful targeted therapy. Laboratory tests also support this finding. Nevertheless, some organ systems are not assessed like respiratory, cardiovascular or cutaneous damage, important in some syndromes. Knowing the difficulties of applying an unified index for all diseases, ADDI may be supportive in other AIDs and longitudinal cohorts.

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AB1012 HENOC-SCHÖNLEIN PURPURA AND UVEITIS, AN UNUSUAL ASSOCIATION

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Background: Henoch-Schönlein purpura (HSP) is the most common childhood vasculitis characterized by cutaneous palpable purpura predominantly located in the lower limbs, arthralgia/arthritis, renal and bowel involvement. To our knowledge only 4 cases of HSP with ocular involvement have been reported so far.

Objectives: We describe a 6-year-old female patient who presented HSP and panuveitis.

Methods: Describe a case report.

Results: A 6-year-old female, previously in good health, received the diagnosis of HSP for cutaneous palpable purpura on her lower limbs, bilateral ankle arthritis and haematuria. Two weeks later the girl was admitted to our Emergency Department due to monolateral ocular pain with red eye. At ophthalmological assessment there was evidence of anterior uveitis with and edema of the optic disc. Blood tests showed increased values of CRP (1.92 mg/dl) and ESR (69 mm/h) with normal values of complement levels and complete blood count. Urinalysis displayed mild hematuria and proteinuria. Immunoglobulin levels were slightly increased: IgG (1850 mg/dl, n.v. 540-1330 mg/dl), IgA 244 mg/dl (n.v. 50-240 mg/dl) and IgM 72 mg/dl (n. v. 50-180 mg/dl) An extensive infectious work-up for viral, bacterial and parasitic infections was negative. ANA, ANCA, ASCA, LAC, HLA B27 and B51 were all negative. Chest X ray, abdominal ultrasound and echocardiography were negative. A brain MRI with contrast revealed an iris inflammation and excluded CNS involvement. Systemic therapy was started with i.v. methylprednisolone (30mg/kg/d for three consecutive days) and continued with oral prednisone (2 mg/kg/day), with a progressive improvement of the ocular, skin, nephrological and articular involvement. Prednisone was then gradually tapered over 2 months without disease recurrence.

Conclusion: In our literature search we were able to find an association between HSP and uveitis only in two adults and in an 11-year-old child. All these patients showed cutaneous and articular involvement and 3/4 nephrological involvement. Uveitis was observed in the first week of

vasculitis onset. Although rare, the presence of ocular involvement can occur during HSP.

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AB1013 CHILDREN IN RISK OF LOW BONE MASS HAVE MORE THAN 2 RISK FACTORS

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Background: Low Bone Mass (LBM)/Infantile Osteoporosis (IOP) require an active evaluation for its diagnosis and prevention. Therefore, its incidence is unknown and could be undertreated. The systematic collection of risk factors associated with LBM/IOP could help identify the population at risk of presenting it

Objectives: To assess the prevalence and number of risk factors (RF) in the pediatric population at risk of developing LBM/IOP. Assess its influence on Bone Mineral Density

Methods: Demographic and clinical data were prospectively collected from patients from 2 to 20 years of age, who had at least one risk factor for LBM/IOP, among them: chronic diseases, treatment with immunosuppressants and/or corticosteroids and insufficient calcium intake. Calcemia, calciuria, and Vitamin D were determined in blood samples, and whole body and lumbar DXA were performed. The calcium intake, the number of previous fractures and other RF were collected

Results: Data were collected from 103 patients, with an average age of 9'8 years, 52'4% women, and 80% Caucasians. Of these, 9 were pre-schoolers (2-3 years old), 33 schoolchildren (4-9y), 55 teenagers (10-17th) and 6 young people (18-20th)

The most frequent diagnoses were: Malabsorption/Food allergies: 46.6%, JIA: 17.5%, Nephropathies: 17.8%, Hematological diseases: 6.8%, and Vasculitis and connective tissue diseases: 3.9% each

The frequency of RFs can be observed in Table 1

	%
Insufficient calcium intake in the diet	84.5
Association of a second chronic diagnosis	4.9
Hypovitaminosis D in blood (<30 nmol/L)	8.1
Sedentary lifestyle (PAQ test <2)	13.6
History of long bone or vertebral fractures	12.6
24-hour urine hypercalciuria	3.1
Proteinuria ≥ 0.20 g/L in 24-hour urine	17
Drugs with osteopenic potential (non-corticosteroid immunosuppressants)	31.1
Corticosteroids at the time of inclusion	19.4
Corticosteroids prior to inclusion in the study	18.4

The average dose of current corticoids was 0.21 mg/kg/day of prednisone with a total cumulative average dose of: 7 gr, with an exposure of 1 to 144 months

4'3% of the sample had an isolated RF, 38% had 2 RF, 31% 3, 15% 4, and 12% 5 or more

8'7% of the sample presented a LBM and 4.8% met criteria for Opi for vertebral fractures, 3 of them asymptomatic and discovered by morphometry

In the multiple linear regression analysis: age, latin ethnicity, gender, and hypovitaminosis D were the main RFs related to lumbar BMD. Likewise,

age, latin ethnicity and sedentary lifestyle were the RF related to the BMD of the whole body without head (BMDwbwh). In lumbar BMD, these 4 RF explained up to 85% of the BMD variation, where the age adds 0'032 per year gained, the male sex subtracts 0'061, the hypovitaminosis D sum 0'077 and the latin ethnicity subtracts 0'070.

Up to a 90'8% variation of BMDwbwh is explained by these 3 RF: age adds 0'036 per year gained, sedentary life subtracts 0'084 and latin ethnicity subtracts 0'055.

Conclusion: The child population at risk of LBM/IOP associates 2 or more risk factors.

8.7% of children with risk factors have LBM and 4.8% IOP.

The RFs related to changes in BMD are: age, sex, sedentary lifestyle and ethnicity. Hypovitaminosis D correlated positively with lumbar BMD.

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AB1014

USE OF ETANERCEPT BIOSIMILAR IN JIA: PRELIMINARY EXPERIENCE USING REAL WORLD DATA

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Background: Biosimilars are biological medical drugs that are almost an identical copy of an original drug, manufactured by a different company. Since last year regional regulations have imposed a non-medical switch from reference etanercept (ETN) originator to biosimilar (SB4). We compared treatment survival on SB4 to reference etanercept, assessing efficacy and safety data in our cohort of patients with JIA.

Objectives: To review clinical charts of JIA patients, including efficacy and safety of ETN biosimilars after transition from originator. Compliance was also assessed.

Methods: This was a retrospective observational study of patients with JIA who switched from reference etanercept to SB4 starting during 2018 in our Pediatric Rheumatology Department. Clinical and demographic data were collected from charts and inserted into a dedicated database. relevant data included: age at disease onset, age at first administration and duration of treatment, if patients had remission of disease with etanercept therapy or if there were any relapses, ESR and CRP values before and after etanercept therapy, ESR and CRP values before switch to SB4 and after SB4 onset, any adverse effects or relapses of disease after biosimilar.

Results: A total of 14 patients (13F, 1M) were identified. Age at diagnosis ranged from 1 to 12 years. Before ETN, all had received methotrexate. ETN was added for disease activity persistence, and induced remission in all cases but one. SB4 treatment duration ranged from 1 to 11 months. After switch to SB4 no disease recurrence was observed. CRP levels, initially elevated in 8/14 cases, normalized during reference etanercept treatment and remained within normal values in all cases during SB4 treatment. ESR median value initially was 40 mm/h (elevated), normalized during reference etanercept treatment (ESR median value 7 mm/h) and remained within normal values (ESR median value 8 mm/h), in all cases during SB4 except one. No side effects were seen, and all families accepted willingly the new prescription.

Conclusion: Our preliminary experience shows that a switch from originator to a biosimilar did not lead to loss of efficacy or new safety signals. Our preliminary results suggest that transitioning from reference etanercept to SB4 is associated with sustained efficacy and no change in the adverse event profile. In conclusion SB4 may provide therapeutically equivalent alternative in pediatric patients with JIA.

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AB1015

CENTRAL NERVOUS SYSTEM VASCULITIS PRECEDING

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Background: Henoch-Schönlein purpura (HSP) is a systemic small vessel vasculitis and represent the most common cause of non-thrombocytopenic

purpura in children; vasculitis very rarely can involve internal organs. Central nervous system (CNS) is exceptional.

Objectives: We report the case of a patient with CNS vasculitis who presented HSP 4 months after the stroke and during corticosteroid withdrawal.

Methods: Case report

Results: A 9-year-old Caucasian boy was admitted to our hospital due to sudden onset of severe headache and left faciobrachial hemiparesis associated with facial palsy and dysarthria. Brain MRI revealed hyperintense signal changes in amygdala, putamen, and internal capsule, suggestive of recent cerebral ischemic lesion. Magnetic resonance angiography showed asymmetry of internal carotid arteries and middle cerebral artery stenosis, suggestive for a vasculitic-inflammatory nature. He received high dose intravenous methylprednisolone, followed by oral corticosteroids with nearly complete recovery. He was discharged on oral prednisone and low-dose aspirin. In the following months a slow tapering of prednisone was attempted. Four months after the stroke, while receiving prednisolone 0.5 mg/kg/day, he presented with sudden onset of purpuric rash on extensor surfaces of the lower extremities, buttocks and arthralgia of the upper and lower extremities. Painful scrotal swelling and abdominal pain were also present. Serial urinalyses were normal. The patient underwent a second MRI of the brain, which ruled out new-onset inflammatory lesions. Therefore, he received intravenous high dose steroids, with complete remission. Sequencing of adenosine deaminase 2 (ADA2) gene ruled out ADA2 deficiency.

Conclusion: We report a case of CNS vasculitis preceding HSP by several months; intriguingly, HSP developed while the patient was under corticosteroid treatment. The exact nature of the association needs to be clarified, to determine if the association was determined by a common pathogenic mechanism or by chance.

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AB1016

OUTCOME OF TRANSITION OF CARE IN YOUNG ADULTS WITH JUVENILE ONSET CHRONIC RHEUMATIC DISEASES

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Background: The transition process of adolescent care from a paediatric to an adult medical environment may affect the compliance with the management plan. Paediatric care is family oriented and relies on significant parental involvement in decision making. On the contrary, adult care is patient-specific and requires autonomy and independent skills.

Objectives: The aim of this study was to evaluate the transition of care at our centre, namely the adherence to clinical appointments, modification of disease activity and patient satisfaction.

Methods: All consecutive patients with juvenile onset of rheumatic chronic diseases followed in a young adult clinic were included. Disease activity was evaluated at the last appointment in the paediatric unit and up to 2 years after transition of care, according to validated scores for each rheumatic disease. Dropout was defined as not attending the clinic for 2 consecutive visits. Global assessment of patient satisfaction with the clinical