appointments before and after transition of care was evaluated in a scale of 0 to 10. Variables were analysed as means, medians and frequencies as appropriate. Univariate analysis was performed with student t-test and Qui-square.

Results: 126 patients were included. Of these, 77 (61.1%) had juvenile idiopathic arthritis (JIA, see table 1 for list of diagnosis), 78 (61%) were female with a mean age of 23.1±3.2 years and a mean disease duration of 12.7±5.3 years. During the transition of care, 92 patients were treated with conventional disease modifying antirheumatic drugs (73%) and 35 with biologic therapy (27.8%). 69 patients (54.7%) missed at least one clinical appointment with a dropout rate of 9%. This was associated with longer disease duration (15.9 vs 12.3 years, $p=0.024$). 11 patients (8.7%) had worsened clinical activity: 5 patients with polyarticular JIA with arthritis flare (Δ DAS28 2.14 ± 0.83); 4 patients with oligoarticular JIA with new onset uveitis and 2 patients with juvenile systemic lupus erythematosus with a SLEDAI increase from 5 to 16 points. 4 patients abandoned DMARDs. Regarding patient satisfaction questionnaire, paediatric rheumatology appointments had a median evaluation of 9 (7-10), adult rheumatology appointments of 8 (5-10) and the transition process had an evaluation of 8 (5-10). The majority of patients reported the longer appointment waiting time as the major negative aspect after transition.

Conclusion: In our centre the transition of care had a small percentage of dropping out from the clinic, which was associated with longer disease duration, a slight worsening of disease activity and a 10% decrease in patient satisfaction.

REFERENCES

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Abstract AB1016 Table 1. Descriptive analyses of diagnosis. SLE - systemic lupus erythematosus. *Mixed connective tissue disease, Systemic sclerosis, Raynaud phenomenon, Overlap syndrome, Osteoporosis, Osteogenesis Imperfecta, Spondyloarthritis

Diagnosis	N (%)
JIA	77 (61.1)
Persistent Oligoarthritis	22 (17.5)
Enthesitis related arthritis	22 (17.5)
Rheumatoid factor - polyarthritis	11 (8.7)
Extended Oligoarthritis	9 (7.1)
Systemic	6 (4.8)
Psoriatic Arthritis	4 (3.2)
Rheumatoid factor + polyarthritis	3 (2.4)
Systemic lupus erythematosus	14 (11.1)
Vasculitis	9 (7.1)
Autoinflammatory syndrome	5 (4)
Dermatomyositis	3 (2.4)
Other diagnosis*	19 (15.1)

Disclosure of Interests: None declared

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AB1017 WHAT IS THE CURRENT SITUATION OF THE PAEDIATRIC RHEUMATOLOGY TRANSITION CARE UNITS?

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Background: Switching from paediatric rheumatology to the adult rheumatology care units has a negative impact on disease control and adherence in young patients with juvenile idiopathic arthritis (JIA) but also in other chronic diseases. Transitional care services provide the opportunity of being followed-up by an adult rheumatology specialized in juvenile rheumatic diseases.

Objectives: In our study we report the current situation of a rheumatology transition care unit (RTCU).

Methods: We set up an observational and retrospective study of patients followed in our unit between September 2015 and December 2018. We included those patients with a disease beginning at 16 years or younger and those patients who were attended on RTCU for the first time before age 25. Clinical and demographic data and all treatments received by the patients before and after the first visit in the transition care unit were also collected.

Results: 119 patients were attended in our RTCU. After applying the exclusion criteria, 110 patients remained: 78 female/32 male (70.9/29.1%) with a median age of 18.5 [17.9-19.8] years at the first visit. No significant differences in age at the first visit were found between the first (September-2015 to September-2017) and the second stage (October-2017 to December-2018), 18.7 (17.8-20.2) vs. 18.2 (17.9-18.6) years respectively. The most frequent diagnoses are included in the **table 1**.

Of the 75 patients with JIA, 54 were women (72%) with a median age at the disease onset of 6.88 [2.3-12.7] and 21.3% of patients had chronic anterior uveitis. 22 patients (29.3%) presented joint or ocular inflammatory activity or flare at the time of transition first visit but only 1 patient maintained inflammatory activity during the 3 years of follow-up.

A total of 64 patients (85.3%) with JIA diagnosis were under treatment with synthetic DMARD, mostly methotrexate (61) or leflunomide (7). In addition, 43 patients (57.3%) required biological DMARD in the past, and 8 of them (10.7%) required more than one. The most frequently used drugs were: etanercept (ETN) (29 patients) and adalimumab (ADA) (19 patients). Tocilizumab (TCZ) (4), abatacept (1) and infliximab (1) were also used.

Of these patients, at the time of the first visit on RTCU, 24 (32%) had no treatment, 42 patients (56%) had synthetic DMARD and 34 patients (45.3%) had biologic therapy in monotherapy or combined with DMARDs (19 ETN, 12 ADA, and 3 TCZ).

Table 1.	Patients RTCU (N=110)
Baseline demographic data	
Years at the time of transition, median [IQR]	18.5 [17.9-19.8]
Sex, n (%)	78F/32M (70.9/29.1%)
ANA +, n (%)	42 (38.2)
RF +, n (%)	1 (0.9)
Most frequent disease, n (%)	
- JIA	75 (68.2)
o JIA (Persistent oligoarthritis)	27 (36)
o JIA (Extended oligoarthritis)	11 (14.7)
o JIA (RF + polyarthritis)	18 (24)
o JIA (RF - polyarthritis)	1 (1.3)
o Enthesitis-related arthritis	9 (12)
o Systemic JIA	4 (5.3)
o Psoriatic JIA	5 (6.7)
- Collagenosis	11 (10)
- Others	24 (21.8)
Previous treatment (JIA patients)	
- Oral glucocorticoids, n patients (%)	40 (36.4)
o Maximum dose (mg/d), mean±SD	21.5±11.7
- Synthetic DMARD, n patients (%)	64 (85.3)
o Methotrexate, n	61
o Leflunomide, n	7
- Biological DMARD, n patients (%)	43 (57.3)
o Etanercept, n	29
o Adalimumab, n	19
o Infliximab, n	1
o Tocilizumab, n	4
o Abatacept, n	1
Treatment at first visit RTCU (JIA patients)	
- Synthetic DMARD, n patients (%)	42 (38.2)
o Methotrexate, n	38
o Leflunomide, n	5
- Biological DMARD, n patients (%)	34 (31)
o Etanercept, n	19
o Adalimumab, n	12
o Infliximab, n	3
RTCU follow-up (years) mean±SD	2.2±1.1

Conclusion: RTCU assessed mainly patients with JIA and connective tissue diseases. Most patients were inactive during the transfer to the adult unit, but the existence of patients that were still active and/or needed treatment with synthetic and/or biological DMARD reaffirms the need for close control in this period.

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AB1018 CONE BEAM CT IN JUVENILE IDIOPATHIC ARTHRITIS: ROLE OF IMAGING DIAGNOSTIC TOOL WITH MINIMAL X-RAY EXPOSURE IN THE FREQUENT, SUBTLE AND INDOLENT TEMPOROMANDIBULAR JOINT INVOLVEMENT

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Background: The prevalence of the temporomandibular joint (TMJ) involvement in patients affected by juvenile idiopathic arthritis (JIA) ranges from 17% to 87% depending on population. TMJ is frequently the first and unique joint involved in the arthritic process. Unfortunately detection of TMJ arthritis in children with JIA is difficult as early signs and symptoms are missing in most patients. Therefore failure to diagnose and treat TMJ arthritis may have severe consequences on masticatory function, like