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.

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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

pain at biting, chewing and yawning and moreover mandibular growth can be impaired and facial asymmetries may develop. Although Magnetic Resonance Imaging (MRI) is the gold standard to identify TMJ involvement, it is affected by lack of informations about bone components. Cone beam CT (CBCT), an imagine diagnostic tool with minimal xray exposure, thanks to its 3D studies provides an accurate image of anatomical bone alteration.

Objectives: Provide a screening imaging tool for TMJ involvement in JIA patients so TMJ dysfunction can be detected and managed at an early stage.

Methods: Eighteen patients affected by JIA from 2 to 16 years of age were included in this prospective study (M/F, 3/15); they were all admitted to a Pediatric Rheumatology and Maxillofacial Surgery Integrated out-patient ambulatory, where an experienced surgeon focused on evaluation of TMJs. All symptomatic patients (uni or bilateral TMJ's pain) performed MRI: anomalous imaging such as increased joint enhancement or intra-articular effusion, was treated with intra-articular corticosteroid injections (IACI). After about two month from intra-articular treatment CBCT was performed in all the enrolled patients (symptomatic and not).

Results: CBCT is a useful tool to improve the diagnostic and therapeutic iter of TMJ involvement in JIA; in fact on one hand it highlights the unsuccessful and palliative role of IACI and on the other hand it can reveal significant impairment of the joint bone components in frequent asymptomatic patients; systemic therapy from the early phase of TMJ involvement could prevents the irreversible modification of the mandibular growth process of undertreated inflammation

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AB1019

THE EFFECT OF TREATMENT REGIMEN ON HEALTH-RELATED QUALITY OF LIFE AND FUNCTIONING IN CHILDREN WITH UVEITIS

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Background: Pediatric non-infectious uveitis can lead to ocular complications and blindness. Complex treatment regimens are often needed and consist of frequent topical treatments (glucocorticoids, mydriatics, glaucoma medications) and systemic immunosuppression.

Objectives: To examine the impact of topical and systemic treatment on health-related quality of life (HRQOL), mental health, and uveitis-related quality of life (QOL) of children with uveitis.

Methods: We reviewed records of 40 children with uveitis (22 JIA-associated uveitis (JIA-U), 18 other uveitis types). Parents and patients completed questionnaires on general QOL (Pediatric Quality of Life Inventory-PedsQL), depression and anxiety (Revised Children's Anxiety and Depression Scale- RCADS), physical functioning (Childhood Health Assessment Questionnaire- CHAQ), and visual function and uveitis-related QOL (Effect of Youngsters' Eyesight on QOL-EYE-Q). We used ANOVA and T-Test to compare treatment groups: 1) topical only vs. systemic only vs. combined topical and systemic treatment; 2) topical vs. no topical treatment.

Results: Of 40 children most were non-Hispanic (98%), Caucasian (80%), and female (70%). Most had bilateral (73%), anterior disease (83%), with minimal disease activity (93% inactive uveitis) and normal vision (100% visual acuity 20/40 or better).

When comparing by treatment group, there were worse EYE-Q Parent and Child uveitis-related QOL scores among the children of the topical treatment only group compared to those on systemic treatment only or the combined treatment group, however they were not statistically significant. (Parent: 1.57 vs. 1.83 vs. 1.6, p=0.13)(Child: 1.68 vs. 1.9 vs. 1.7, p=0.20).

However, when comparing children by use of topical treatment, children on topical treatment had worse EYE-Q total scores compared to those who were not on topical treatment for Parent reports (1.75 vs. 1.93, p=0.01) (Table 1). They also had worse EYE-Q visual function scores (1.82 vs. 1.96, p=0.02) and uveitis-related QOL scores (1.59 vs. 1.83, p=0.04). For child reports, EYE-Q total score and subscores were lower in the topical treatment group but were not statistically significant.

Children with uveitis had similar Parent and Child reports of PedsQL, RCADS, and CHAQ regardless of treatment group.

Table 1. Vision-Specific Outcome Measures by Treatment Regimen in Children with Uveitis

Measure	No Topical Rx (n =11)	Topical Rx (n = 24)	P Value
EYE-Q Parent Total	1.93 (0.07)	1.75 (0.26)	0.006*
Visual Function	1.96 (0.06)	1.82 (0.26)	0.021*
Uveitis-related QOL	1.83 (0.19)	1.59 (0.33)	0.041*
EYE-Q Child Total	1.87 (0.18)	1.71 (0.3)	0.12
Visual Function	1.86 (0.23)	1.73 (0.34)	0.254
Uveitis-related QOL	1.9 (0.19)	1.69 (0.34)	0.07

*p<0.05

Conclusion: The parents of children with uveitis who need topical treatments as part of their therapy regimen report worse uveitis-related QOL. This is likely secondary to parental responsibility for instilling topical therapy. Additionally, visual function scores were also lower in the topical treatment group and could reflect disease activity or use of mydriatics which can affect vision. Other measures including the PedsQL, CHAQ, and RCADS did not appreciate differences based on treatment regimen. Our findings demonstrate the importance of including uveitis-specific disease measures in the assessment of the impact of uveitis. The burden of medication use, specifically eye drops, that can sting, require frequent application, or affect vision, needs further study as this can affect medication adherence and patient outcomes.

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AB1020

DISEASE ACTIVITY INDEX IS ASSOCIATED WITH SUBCLINICAL ATHEROSCLEROSIS IN CHILDHOOD-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is considered an independent risk factor for cardiovascular events in association with traditional risk factors. Therefore, it is important to recognize and to identify the specific risk factors for atherosclerotic disease in these patients for the prevention and early treatment of cardiovascular diseases, aiming to provide a better quality of life with long-term morbidity reduction.

Objectives: To determine the prevalence of subclinical atherosclerosis by the measurement of carotid intima-media thickness (CIMT) in patients with childhood-onset systemic lupus erythematosus (cSLE) younger than 21 years. To check for associations between sex, age, race, body mass