guide ophthalmologic screening in JIA patients in order to identify children likely to develop uveitis.

REFERENCES

Disclosure of Interests: None declared

AB1023

PHYSICAL ACTIVITY LEVEL IN PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS: A COMPARISON WITH THE GENERAL POPULATION

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Background: Insights in pathogenesis and the availability of new biologic drugs have created requirements and an increasing interest for encouragement of physical activity (PA) as long-term treatment option in patients with juvenile idiopathic arthritis (JIA). A low level of PA in healthy individuals is related to a higher incidence of overweight and hyper tension in later life. This low level of PA might even be more dangerous for children with JIA, as they also have elevated inflammatory parameters, perhaps increasing the risk of future cardiovascular diseases.

Objectives: Since children and adolescents with physical disabilities may have an increased risk for developing a sedentary lifestyle, the objective was to investigate if encouragement of PA in most German medical care settings has led to PA levels in JIA similar to that of healthy counterparts.

Methods: Data from children and adolescents with JIA included in the German National Paediatric Rheumatologic Database (NPRD) in the year 2017 were considered for the analyses. In accordance with the methodology used in the general population survey [1], the achievement of the WHO recommendations on PA for health was determined on the basis of self-reported outcomes in individuals aged 3 to 17 years. Patients met the WHO criteria if they stated to be physically active for at least 60 minutes per day.

Results: In 2017, the data from 5,918 patients (mean age 11.2 ± 4 years, 48% female, 67%, disease duration 4.6 ± 3.7 years, persistent oligoarthritis 42%) were available for evaluation. Almost 35% of patients aged 3 to 17 years met the recommended physical activity level (72% aged 3 to 6; 47% aged 7 to 10; 27% aged 11 to 13; 16% aged 14 to 17). In the general population, 26% fulfilled the WHO recommendations on PA for health determined on the basis of self-reported outcomes in individuals aged 3 to 17 years. Patients met the WHO criteria if they stated to be physically active for at least 60 minutes per day.

Abstract AB1023 Table 1. Therapy prior and post RTX in patients with pSLE

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prior to RTX</th>
<th>At 1 year</th>
<th>At 2 year</th>
<th>At 3 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prednisolone</td>
<td>17(100%)</td>
<td>(n=17)</td>
<td>14(100%)</td>
<td>12(100%)</td>
</tr>
<tr>
<td>Hydroxychloroquine</td>
<td>17(100%)</td>
<td>(n=17)</td>
<td>14(100%)</td>
<td>12(100%)</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>7(41%)</td>
<td>(n=17)</td>
<td>12(86%)</td>
<td>10(83%)</td>
</tr>
<tr>
<td>Mycophenolate mofetil</td>
<td>1(6%)</td>
<td>(n=17)</td>
<td>0(0%)</td>
<td>0(0%)</td>
</tr>
<tr>
<td>Cyclosporin</td>
<td>1(6%)</td>
<td>(n=17)</td>
<td>0(0%)</td>
<td>0(0%)</td>
</tr>
<tr>
<td>Tacrolimus</td>
<td>1(6%)</td>
<td>(n=17)</td>
<td>0(0%)</td>
<td>0(0%)</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>2(12%)</td>
<td>(n=17)</td>
<td>1(7%)</td>
<td>1(7%)</td>
</tr>
<tr>
<td>Azathioprine</td>
<td>1(6%)</td>
<td>(n=17)</td>
<td>0(0%)</td>
<td>0(0%)</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>1(6%)</td>
<td>(n=17)</td>
<td>0(0%)</td>
<td>0(0%)</td>
</tr>
</tbody>
</table>

Acknowledgement: The National Paediatric Rheumatological Database has been funded by the German Children Arthritis Foundation (Deutsche Kinder Rheumastiftung), AbbVie, Pfizer and Chugai.

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AB1024

USE, EFFICACY AND LONG TERM SAFETY OF RITUXIMAB IN PEDIATRIC RHEUMATIC DISEASES: SINGLE CENTER EXPERIENCE FROM NORTH INDIA

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Background: Rituximab(RTX) is used in pediatric rheumatic diseases as an off label indication. There is paucity of data on safety and long term efficacy in countries with high burden of infectious diseases.

Objectives: 1. To study the use and safety of RTX in pediatric rheumatic diseases
2. To assess the long term efficacy of RTX in pediatric systemic lupus erythematosus(pSLE).

Methods: Data of all children who received RTX was collected on standardized collection forms. This data set was reviewed. Children with pSLE who were given RTX were included for efficacy analysis. Screening, use and safety were evaluated for all patients.

Results: USE: Rituximab was given to 4 children with polyarticular juvenile idiopathic arthritis(PJIA)(4/145=2.7%) and 17 children with pSLE(17/225=7.5%). In children with PJIA, RTX was used as third line treatment, who failed methotrexate and TNF inhibitor therapy. In pSLE, lupus nephritis was the primary indication for RTX(96%), vasculitis(17%), neuro-psychiatric SLE and refractory cytopenias(12%) each and aggressive polyarthritis with steroid dependence(5%). SAFETY: Prebiologic screen for HIV, Hepatitis B and C and tuberculosis was negative. Total immunoglobulinG level was assayed prior to RTX for all children. CMV PCR was done in 11/17 pSLE patients. No immediate or delayed anaphylaxis was noted. No child had reactivation of herpes zoster. There was no mortality in this cohort.

EFFICACY: Studied in 17 children with pSLE over 21 episodes of RTX(2 received 3 cycles of RTX over 5 years). Median age at RTX use was 13.66 years(range 6.58-21.66 years). Median duration of follow up was 48 months(range 3-120 months). During long term follow up 14 patients did not have any disease flare. Three(17.6%) flared and required cyclophosphamide/second cycle of RTX. Mean dose of prednisolone prior to RTX was 0.7mg/kg/day while that at 1 year post RTX was 0.05mg/kg/day(p value 0.001) and at 2 years was 0.05mg/kg/day(p value 0.003). Mean SLE disease activity index 2K(SLEDAI-2K) prior to RTX was 16.25 while that at 1 year post RTX was 12.5(p value 0.004), at 2 years was 2(p value 0.004) and at 3 years was 0.85(p value 0.028).

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Conclusion: We conclude that RTX is efficacious for use in severe spectrum of pSLE and is relatively safe to use even in a developing country like ours with huge infectious disease burden.

REFERENCES

Disclosure of Interests: None declared

AB1025
HARMONIZING JAPANESE VERSION OF THE CHILDHOOD HEALTH ASSESSMENT QUESTIONNAIRE (CHAQ) WITH CHAQ
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Background: Juvenile idiopathic arthritis (JIA) is one of the most common rheumatic diseases of childhood. The Childhood Health Assessment Questionnaire (CHAQ) is one of the most widely-used self-report questionnaires to measure patient disability and discomfort (1). The American English version of the CHAQ was previously translated into Japanese, cross-culturally adapted and validated in a cohort of healthy Japanese children and Japanese patients with JIA (2).

Objectives: To revise the Japanese version of the CHAQ (JCHAQ) to meet requirements of clinical international trials that pool data from various centers in different countries which need the same number of questions in each functional area of the CHAQ and to validate the harmonized JCHAQ with JIA patients.

Methods: The questionnaire in the JCHAQ consisted of 36 items, measuring eight functions: arising, dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities, was changed to 30 items of questionnaire as each functional area has same number of questions as the original American English version after a conference among pediatric rheumatologists in US and Japan. The revised version was professionally translated from English to Japanese and reviewed by the rheumatologists for accuracy. Then, it was validated with Japanese JIA patients.

Results: A total of 42 JIA patients were enrolled in the validation: 7 systemic, 30 polyarticular/oligoarticular and 5 enthesitis related. Most patients were well controlled and the median disability index (DI) scores was 0.0, however, significant correlation was seen with VAS (Visual Analog Scale) of pain, VAS overall well-being, physician VAS, DAS (Disease Activity Score)28-ESR, and JADAS (Juvenile Arthritis Disease Activity Score)-27. All variables in the questionnaire were shown to be significant (P<0.001).

In comparison of two groups of disease activity, remission/mild vs. moderate/severe, both DAS28-ESR and JADAS27 showed significant correlation with DI.

Conclusion: The Harmonized JCHAQ was a reliable and valid tool for the functional assessment of children with JIA. It is more suitable for international comparison.

REFERENCES

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