site preceded distant or systemic manifestations. Abnormal blood tests were common. Localised inflammatory nodules and panniculitis in 88.88% evolved into a variety of disorders, viz., primary biliary cirrhosis, Sjögren's syndrome, sarcoidosis, human adjuvant disease, vasculitis, inflammatory bowel syndrome and inflammatory polyradiculopathy. 11.11% cases presented primarily with systemic autoimmune disorders.

Conclusion: Biomaterials and prostheses can provoke late-onset systemic autoimmune disorders fulfilling ASIA criteria, or present primarily local/regional inflammatory reactions that may eventually evolve into systemic autoimmune and/or granulomatous disorders which fall under ASIA

REFERENCES

- [1] Hanke CW, Rohrich RJ, Busso M, Carruthers A, Carruthers J, Fagien S, et al. Facial soft-tissue fillers: assessing the state of the science conference proceedings report. *J Am Acad Dermatol*. 2011;64(4 Suppl):S53-65.
- [2] Ellis DA, Makdessian AS, Brown DJ. Survey of future injectables. *Facial Plast Surg Clin North Am*. 2001;9:405-11.
- [3] American Society of Plastic Surgery. Statistics of 2010, http://www.surgery.org/site/default/stats2010_1.pdf (2010, Accessed 01 Aug 2011).

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.3234

AB1075 IDIOPATHIC ORBITAL PSEUDOTUMOUR: A CASE SERIES AND LITERATURE REVIEW

Edna Amaya Cabrera, Sergio Cerpa-Cruz, Veronica Gonzalez-Diaz, Gloria Martinez-Bonilla, Sergio Gutierrez-Ureña, Marisol Iniguez Soto. *Hopital Civil Fray Antonio Alcalde, Reumatologia, Mexico, Mexico*

Background: Idiopathic orbital pseudotumour (IOP), also known as idiopathic orbital inflammatory syndrome is a benign, non-infective, inflammatory condition of the orbit without identifiable local or systemic causes. After Grave's disease and lymphoproliferative disorders, orbital pseudotumour is the 3rd most common ophthalmologic disease of the orbit and account for approximately 8-11% of all the orbital tumors. Pathogenesis of orbital pseudotumour remains elusive but several lines of evidence point to immune-mediated processes as the likely underlying ocular mechanism. The etiology of orbital pseudotumour is unknown, but infection, autoimmune disorder, and aberrant wound healings have been put forward as possibilities. The ocular manifestations of orbital pseudotumour may include periorbital edema, erythema, proptosis, ptosis, diplopia and pain with eye movements.

Objectives: Describe clinical and demographic characteristics, most frequent diagnoses, immunological serology and treatments in patients with Orbital Pseudotumour.

Methods: We performed a retrospective cohort study of adult and pediatric patients with orbital pseudotumour diagnosis referred to the Department of Rheumatology of the Fray Antonio Alcalde Civil Hospital in Guadalajara Jalisco, Mexico, from 2012-2018. We collected data that included demographic data of the patient, symptoms, laboratory data that included antibodies, management plans and results.

Results: A total of 20 patients diagnosed with orbital pseudotumour, with a mean age of 42±18.5 years, 3 pediatric patients and 65% women. Clinical manifestations were: 90% unilateral, 90% lacrimal gland involvement, 75% ptosis/proptosis, 40% conjunctival hyperemia, 35% ocular pain, 20% decreased visual acuity, 15% headache and no optic nerve involvement. The findings were similar between adults and children.

The most common diagnoses were: 40% idiopathic, 10% orbital cellulitis, 10% granulomatosis with polyangiitis and 5% each of the following: systemic lupus erythematosus, Sjögren's syndrome, dacryoadenitis and myositis due to IgG4, Kimura's disease, Mikulicz, meningioma and cavernous sinus aneurysm.

All patients underwent excisional biopsy, and the histopathological report showed the following findings: 40% non-specific chronic inflammation, 30% non-specific chronic dacryoadenitis, 5% granulomatous inflammation/vasculitis, 10% chronic sclerosing inflammation-IgG4 and 15% others.

Only 9 of the 20 patients underwent immunological serology, finding positivity in: 15% for c-ANCA, 10% PR3, 5% p-ANCA, 10% MPO, 5% ANAs and 10% elevated blood levels of IgG4.

Regarding treatment, 100% received glucocorticoids, and received immunomodulatory therapy: 20% received azathioprine, 5% mycophenolate mofetil, 20% methotrexate, 15% cyclophosphamide IV, 15% rituximab and 25% received no other medication.

Conclusion: The orbital pseudotumour might be the first manifestation of an autoimmune or autoinflammatory disease, the early and correct diagnosis is necessary to avoid permanent sequelae.

REFERENCES

- [1] Yuen SJ, et al. Idiopathic orbital Inflammation: Ocular mechanism and clinicopathology. *Ophthalmol Clin North Am* 2002;15:121-6.
- [2] Grouteau E, et al. Acute orbital myositis and idiopathic inflammatory pseudotumor in children: cases. *Arch Pediatr* 1998;5:153-158.
- [3] Chaudhry IA, et al. Orbital pseudotumor: Distinct diagnostic features and management. *Middle East Afr J Ophthalmol* 2008;15:17-27

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.4453

AB1076 TREATMENT REVIEW OF ADULT-ONSET STILL'S DISEASE IN A TERTIARY HOSPITAL

Maria Dolores Arcila Duran, Clara Aguilera Cros, Lara Mendez, Isabel Madroñal García, Marina Gomez Vargas, Alberto Ruiz Román, Esteban Rubio Romero, Juan Povedano Gomez. *Hospital Universitario Virgen del Rocío, Sevilla, Spain*

Background: Adult-onset Still's disease (AOSD) is a rare systemic inflammatory disorder of unknown aetiology, and approximately 60% or 70% of the patients can develop a chronic polyphasic form of the disease or a chronic polyarthritis. Due to the rarity of this disease, the treatment of AOSD is not based on a controlled study, but in the experience based on real cases.

Objectives: Describe the different treatments employed in a patient cohort diagnosed with adult-onset Still's disease (AOSD).

Methods: Descriptive, retrospective study of patients treated in our Hospital (2008-2018), diagnosed with AOSD according to the classification criteria of Yamaguchi. The data were achieved by the review of the clinical records.

Results: Twenty-four patients (15 women), average age of 41±13 years, were included. Two women, with presentation on the symptoms at 8 and 3 years old, first diagnosed with systemic juvenile idiopathic arthritis (S-JIA), and then with AOSD.

The initial treatment was based in non-steroidal anti-inflammatory drugs (96%) and glucocorticoids (0.5-1 mg/kg/day) (96%) for symptom control, with the necessity to add oral or subcutaneous methotrexate at a dose of 15 mg per week in 13 patients (54%).

Only two patients used acetyl salicylic acid as initial treatment, with no improvement.

Previous treatment		Current treatment	
Drug	n (%)	Drug	n (%)
NSAIDs	23 (96%)	NSAIDs	2 (8%)
Glucocorticoids	23 (96%)	Glucocorticoids	3 (12%)
DMARDs	15 (62%)	DMARDs	3 (12%)
• Methotrexate	13 (86%)	• Methotrexate	2 (8%)
• Leflunomide	5 (33%)	• Hydroxychloroquine	1 (4%)
• Hydroxychloroquine	8 (53%)		
• Sulfasalazine	2 (13%)		
Biological treatments	5 (21%)	Biological treatments	3 (12%)
• Etanercept	3 (60%)	• Sarilumab	1 (33%)
• Adalimumab	1 (20%)		
• Infliximab	4 (80%)	• Tofacitinib	2 (66%)
• Tocilizumab	2 (40%)		
• Sarilumab	1 (20%)		
• Rituximab	2 (40%)		
• Baricitinib	2 (40%)		
• Tofacitinib	1 (20%)		
Immunosuppressores	4 (17%)	DMARDs + Biological treatments	0
• Azathioprine	2 (50%)		
• Mycophenolate Mofetil	1 (25%)		
• Cyclophosphamide	1 (25%)		
		Without treatment	11 (46%)

Five patients used also biological treatments with a standard doses, with the necessity of various drugs to achieve their clinical remission. Nowadays, all patients have their clinical remission. Patient 1: Infliximab, rituximab, tocilizumab and baricitinib. Patient 2: Etanercept and rituximab. Patient 3: Etanercept, adalimumab and infliximab. Patient 4: Etanercept, infliximab and tofacitinib. Patient 5: Infliximab, tocilizumab, baricitinib and sarilumab (great response to a anti-IL6, tocilizumab were removed because of a local reaction in the injection's spot, although it had a good response too). Two patients with clinical remission with JAK-kinase