site preceded distant or systemic manifestations. Abnormal blood tests were common. Localised inflammatory nodules and panniculitis in 88.88% were due to systemic inflammatory disorder, viz. systemic lupus erythematosus, Sjögren syndrome, sarcoidosis, human adjacent disease, vasculitis, inflammatory bowel syndrome and inflammatory polyarthritis. 11.11% cases presented primarily with systemic autoimmune disorders. Conclusion: Biomaterials and protheses 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

Disclosure of Interests: None declared

AB1076 IDIOPATHIC ORBITAL PSEUDOTUMOUR: A CASE SERIES AND LITERATURE REVIEW
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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 pseudotumor is the 3rd most common ophthalmologic disease of the orbit and account for approximately 8-11% of all the orbital tumors. Pathogenesis of orbital pseudotumor remains elusive but several lines of evidence point to immunological mechanisms as the likely underlying ocular mechanism. The etiology of orbital pseudotumor is unknown, but infection, autoimmune disorder, and aberrant wound healings have been put forward as possibilities. The ocular manifestations of orbital pseudotumor 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 Pseudotumor.

Methods: We performed a retrospective cohort study of adult and pediatric patients with orbital pseudotumor 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 pseudotumor, 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, 40% non-specific chronic dacryoadenitis, 5% granulomatous inflammation. 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 pseudotumor might be the first manifestation of an autoimmune or autoinflammatory disease, the early and correct diagnosis is necessary to avoid permanent sequelae.

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 (good 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

REFERENCES

Disclosure of Interests: None declared

AB1076 TREATMENT REVIEW OF ADULT-ONSET STILL’S DISEASE IN A TERTIARY HOSPITAL
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Background: Adult-onset Still’s disease (AOSD) is a rare systemic inflammatory disorder of unknown etiology, 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.

<table>
<thead>
<tr>
<th>Previous treatment</th>
<th>Current treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>n (%)</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td>23 (90%)</td>
</tr>
<tr>
<td>DMARDS</td>
<td>35 (61%)</td>
</tr>
<tr>
<td>- Methotrexate</td>
<td>11 (19%)</td>
</tr>
<tr>
<td>- Leflunomide</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>- Hydroxychloroquine</td>
<td>6 (11%)</td>
</tr>
<tr>
<td>- Sulfasalazine</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Biological treatments</td>
<td>5 (21%)</td>
</tr>
<tr>
<td>- Infliximab</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>- Atesilopab</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>- Ibutilud</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>- Rasila</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>- Baricitinib</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>- Tofacitinib</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>- Tocilizumab</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Biological treatments</td>
<td>4 (17%)</td>
</tr>
<tr>
<td>- Infliximab +</td>
<td>- Infliximab +</td>
</tr>
<tr>
<td>- Tocilizumab</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>- Baricitinib</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
inhibitors (baricitinib and tofacitinib, respectively), one patient with anti-TNF (infliximab) and another one with anti-CD20 (rituximab).

**Conclusion:** In general, our results match with what is published in the literature.

For the treatment of AOSD has been used high doses of ASA (4g/day) or NSAID. However, the required doses (with their respective adverse effects), its intensive responses and the frequent relapses after its suppression make difficult to maintain it. Nowadays, the systemic glucocorticoids are our first choice (0.5 to 1 mg/kg/day). A high average of our patients have a positive response with it, but in a 54% of the cases were necessary to add methotrexate or others DMARDs because of a partial response with steroids.

In the physiopathology of the AOSD there is an increase of pro-inflammatory cytokines, as the tumor necrosis factor, IL-1 and IL-6. The use of therapies that inhibit these molecules (anti-TNF, anakinra or canakinumab as a drug) or tocilizumab or sarilumab as anti IL-6) is being a progress.

The inhibitors of IL-1 can be more efficient for systemic manifestations, while the inhibitors of IL-6 are for articular and systemic affection. The TNF inhibitors should be used for the articular affection only. In our patient cohort there is no patient with anti-IL, a patient in clinical remission with anti-TNF and another one with anti-IL-6. Prospective studies with a higher number of patients is necessary to define better the AOSD treatment.

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**AB1077**

**ANTI-IL6-RECEPTOR TOCILIZUMAB IN GRAVES’ ORBITOPATHY. MULTICENTER STUDY OF 46 PATIENTS IN CLINICAL PRACTICE**

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**Background:** Graves’ orbitopathy (GO) is the most common and important extrathyroidal manifestation of Graves’ disease. Corticosteroids and conventional immunosuppressors are not always effective or well tolerated. The IL-6 receptor antibody tocilizumab (TCZ) has demonstrated efficacy in the treatment of this pathology.

**Objectives:** To assess the efficacy of TCZ in refractory thyroid associated orbitopathy (TAO) due to Grave’s disease.

**Methods:** Multicenter study of 46 patients with TAO refractory to conventional immunosuppressive therapy. Results: We studied 46 patients (85 eyes) (37 women/9 men); mean age at diagnosis 49.2±11.8 years. Besides oral corticosteroids, before the onset of TCZ patients had been treated with pulses of iv methylprednisolone (42 eyes), radioactive iodine (4), methotrexate (2) and other drugs (sele-nium in 11 cases, methimazole in 8, leflunomide in 1 and azathioprine in 1). Seven patients underwent ocular urgent decompressive surgery.

According to the classification of severity of the EUGOGO group (European Group on Graves’ Orbitopathy) using the clinical activity score (CAS), before TCZ onset patients whose data were available had severe (27 eyes) or moderate (34 eyes) disease. Moreover, patients presented exophthalmos (53 eyes), strabismus (37 eyes), muscle fibrosis (38 eyes) and dysthyroid optic neuropathy (10 eyes). TCZ was used in monotherapy (43) or combined with methotrexate (2) or azathioprine (1) at 8 mg/kg iv/iv w (41) or 162 mg/sc w (5). TCZ yielded rapid and maintained improvement in all ocular parameters as shown in Figures.

**REFERENCES**


**Disclosure of Interests:** Belén Atienza-Mateo: None declared, José Luis Martín-Varillas: None declared, Vanessa Calvo-Rio: None declared, Rosalía Demetrio-Pablo: None declared, Elia Valls-Pascual: None declared, Beatriz Valls-Espinosa: None declared, Olga Maiz-Alonso: None declared, Ana Blanco: None declared, Ignacio Torre-Salaberri: None declared, Verónica Rodríguez-Mendez: None declared, Ángel García-Aparicio: None declared, Raúl Veroz González: None declared, Vega Jovani: None declared, Diana Peiteado: None declared, Margarita Sanchez Orgaz: None declared, Santos Castañeda: None declared, Eva Tomero: None declared, J Francisco, Toyo Sáenz de Miera: None declared, Valvanera Pinillos: None declared, Elena Aurrecoechea: None declared, Ángel Mora: None declared, Arantxa Conesa: None declared, Manuel Fernández: None declared, J. Antonio Troyano: None declared, Iligo González-Mazo: None declared, Laura Sánchez Bilbao: None declared, D. Prieto-Peña: None declared, Monica Calderón-Goercke: None declared, Miguel A. González-Gay: None declared, Ricardo Blanco: None declared

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**AB1078**

**RED CELL DISTRIBUTION WIDTH (RDW) – A NEW POSSIBLE DISEASE ACTIVITY PREDICTOR IN RELAPSING POLYCHONDRITIS**

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**Background:** Relapsing polychondritis (RP) is a rare condition defined by recurrent inflammation of cartilaginous tissue and systemic manifestations. Biomarkers for RP diagnosis and assessment of disease activity, damage and prognostic in clinical practice are currently lacking. Red blood cell distribution width (RDW) is an index of erythrocyte size variation depicting...