phenotypes were associated with specific MSA. After 5 years, 2/3 of patients had an inactive disease, but about half of all patients still received MTX and GC therapy.

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THU0522

CLINICAL MANIFESTATIONS AND COMPARISON OF SUBTYPES OF JUVENILE IDIOPATHIC INFLAMMATORY MYOPATHIES: DATA FROM THE REMICAM REGISTRY

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Background: Juvenile idiopathic inflammatory myopathies (JIIM) are a heterogeneous group of autoimmune diseases affecting children, characterized by symmetric muscular weakness, cutaneous rash and systemic organ involvement. Given its low incidence, there are few studies describing the characteristics of this disease and its subtypes in Spanish patients¹.

Objectives: To describe the demographic, clinical and analytical characteristics of patients with JIIM from the registry of inflammatory myopathies in Madrid community (REMICAM), and to compare those measures between polymyositis (PM) and juvenile dermatomyositis (JDM) subgroups.

Methods: A multicentre retrospective study from the REMICAM registry was performed. Patients were selected if they were 18 years or younger at onset of JIIM and met definite or probable criteria for IIM by the modified Bohan and Peter criteria. We included patients with JDM or PM subgroups, overlap myositis patients were excluded.

Results: 86 patients were included, 12 classified as PM and 74 as JDM. 70% were women and 96% were Caucasian. Mean age at diagnosis was 11.8 years in PM group vs 7.2 years in JDM group. 44% presented arthritis and 93% presented muscular weakness. Gottron sign was present in 76% of the patients, and calcinosis was present in 31.4%. Cardiac and pulmonary manifestations were rare (<5%). There were no cases of neoplastic disease. Clinical features and complementary analysis are shown in table 1 and table 2.

Abstract THU0522 –Table 1. Clinical features

	Total (n=86)	PM (n=12)	JDM (n=74)	p-value
Fever	23 (29,1%)	6 (50,0%)	17 (25,4%)	0,084
Weight loss	12 (15,2%)	1 (8,3%)	11 (16,4%)	0,680
Arthralgia	38 (44,2%)	7 (58,3%)	31 (41,9%)	0,287
Arthritis	24 (28,4%)	6 (50%)	18 (24,7%)	0,071
Gottron sign	66 (76,7%)		65 (87,8%)	
Heliotrope erythema	46 (53,5%)		46 (62,2%)	
Mechanic hands	10 (12,3%)		10 (14,5%)	
Skin ulcers	3 (3,7%)		3 (4,3%)	
Raynaud	12 (13,9%)	3 (25,0%)	9 (12,2%)	0,362
Calcinosis	27 (31,4%)	2 (16,7%)	25 (33,8%)	0,325
Muscular weakness	80 (93,0%)	11 (91,7%)	69 (93,2%)	1,000
Myalgia	68 (83,9%)	8 (66,7%)	60 (87,0%)	0,095
Myocarditis	2 (2,3%)		2 (2,7%)	
Arrhythmia	3 (3,5%)	1 (8,3%)	2 (2,7%)	0,370
Heart failure	1 (1,2%)		1 (1,4%)	1,000
Interstitial lung disease	1 (1,2%)	1 (8,3%)		0,140
Dysphagia	19 (22,1%)	2 (16,7%)	17 (23,0%)	1,000
GI reflux	7 (8,1%)	1 (8,3%)	6 (8,1%)	1,000
GI hemorrhage	1 (1,2%)		1 (1,3%)	1,000

Abstract THU052 –Table 2. Complementary test.

	Total (n=86)	PM (n=12)	JDM (n=74)	p-value
Anemia	13 (15,1%)	4 (33,3%)	9 (12,2%)	0,079
Leukopenia	4 (4,6%)	1 (8,3%)	3 (4,0%)	0,458
Thrombocytopenia	3 (3,5%)	2 (16,7%)	1 (1,3%)	0,050
ANA+	34 (40,5%)	7 (58,3%)	27 (37,5%)	0,173
Anti-Jo1	2 (2,6%)		2 (3,0%)	1,000
CPK	431 (97-3131)	206 (36-7428)	659 (104-3110)	0,730
Aldolase	12 (9-18)	9 (5-12)	12 (9-19)	0,230
CRP	0,35 (0-1,3)	0,12 (0-2,8)	0,42 (0-1,3)	0,817
ESR	19 (11-29)	25 (13-42)	19 (11-29)	0,450
Myopathic pattern	72 (92,3%)	12 (100%)	60 (90,1%)	0,508

Conclusion: JDM was the most frequent form of MIJ in our study (86%). The most frequent manifestations were the muscular and dermatological ones, but an important group also presented arthritis and fever. There was no statistical difference between both groups, regardless, myalgias and dysphagia were more common in JDM group, and they had higher CPK and aldolase values. PM patients were older, had more fever and arthritis, also, cytopenia and ANA positivity were more common.

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THU0523

OBESITY IS ASSOCIATED WITH SEVERE RENAL INVOLVEMENT, PERSISTENT PURPURA AND LONGER JOINT SYMPTOMS IN CHILDREN WITH HENOC SHÖNLEIN PURPURA

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Background: Over the last 20 years, the prevalence of obesity is increased in the developed and developing countries. Adipose tissue has an effect on inflammatory processes and immune system besides metabolic and appetite regulating mechanisms. On this basis, it is now of major interest to clarify the relationship between obesity and autoimmune/inflammatory diseases (1,2).

Objectives: We aimed to evaluate the role of obesity on the clinical course and response to treatment in patients with Henoch Shönlein Purpura (HSP).

Methods: Data charts of children with HSP followed in Dokuz Eylül University Childrens' Hospital were reviewed retrospectively. Obesity was defined as BMI ≥95 percentile in conformity with Centers for Disease Control and Prevention (CDC) (3). Persistent purpura was defined as skin involvement persisting for ≥30 days. Mild nephropathy was defined by the presence of microscopical hematuria and/or nonnephrotic proteinuria, and severe nephropathy by nephrotic syndrome and/or acute nephritic syndrome and/or renal insufficiency (4). Patients were grouped as obese and non-obese depending on BMI. Two groups were compared for demographic, clinical and laboratory parameters.

Results: There were 199 patients [M/F:104/95; presenting age 7.1 years (range 5.0-9.2); follow-up period 17.5 months (range 3-50)]. Obesity was