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Disclosure of Interests: Simon Ronicke Employee of: Ada Health GmbH, Berlin, Martin C. Hirsch Shareholder of: Ada health GmbH, Ewelina Türk Employee of: Ada Health GmbH, Berlin, Katharina Larionov: None declared, Daphne Tientcheu: None declared, Annette D. Wagner: None declared

DOI: 10.1136/annrheumdis-2019-eular.6866

THU0565

COMPARISON OF SURVIVAL RATES AMONG SUBGROUPS OF PATIENTS EVALUATED FOR FEVER OF UNKNOWN ORIGIN

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Background: Fever of unknown origin (FUO) is one of the most challenging clinical situations. Although several studies showed a relatively benign course of patients remained undiagnosed, long-term outcome of patients with a certain diagnosis remain non-established (1).

Objectives: To describe the follow-up results of patients investigated for FUO and had a certain diagnosis.

Methods: Data from patients who admitted to Hacettepe University Hospitals, inpatients sections of department of the internal medicine with the complaint of FUO collected prospectively from January 2015 to October 2017. Patients with an uncertain diagnosis after all diagnostic procedures excluded. Patients were divided into 3 main subgroups: rheumatologic, infectious and malignant groups. We compared Kaplan-Meier curves for all diagnosis-to-death time frames with the standart log-rank test. $p < 0.05$ was considered as statistically significant.

Results: Total 106 patients were included, 58(55%) of them were female. Median age was 48 (18-81) years. Patients were also divided into three subgroups: rheumatologic (RHE) (n=49, 46.2%), infectious (INF) (n=28, 26.4%) and malignant (MLG) (n=29, 27.4%) causes; adult-onset Still's disease (n=20; 41% of), tuberculosis (n=9; 32%) and lymphoma (n=19; 66%) were the most common diagnosis among groups, respectively. Mortality rates in decreasing order were RHE, INF and MLG groups, respectively. As an interaction was found between gender and survival, results of survival analysis were given as stratified according to gender. While there was no survival difference between RHE and INF groups among men, both of these groups had better survival than MLG group (ROM-INF $p=0.13$; ROM-MLG $p=0.001$; INF-MLG $p=0.022$). Among women, only there was a significant survival difference between RHE and MLG groups (ROM-INF $p=0.15$; ROM-MLG $p=0.007$; INF-MLG $p=0.42$).

Conclusion: Among patients evaluated for FUO, survival rate was higher in patients who had a rheumatological diagnosis. Further diagnostic algorithms are needed to identify these subgroups, because of the higher mortality among INF and MLG groups.

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Figure 1. Kaplan-Meier curves of male patients (RHE vs. INF $p=0.13$; RHE vs. MLG $p=0.001$; INF vs. MLG $p=0.022$)

Figure 2. Kaplan-Meier curves of female patients (RHE vs. INF $p=0.15$; ROM vs. MLG $p=0.007$; INF vs. MLG $p=0.42$)

Disclosure of Interests: Emre Bilgin: None declared, Berkan Armagan: None declared, Alper Sarı: None declared, Ertuğrul Çağrı Bölek: None declared, Bayram Farisoğulları: None declared, Gözde Kübra Yardımcı: None declared, Levent Kılıç: None declared, Ali Akdoğan: None declared, Omer Karadag: None declared, Şule Apraş Bilgen: None declared, Ali İhsan Ertenli: None declared, Sedat Kiraz: None declared, Umut Kalyoncu Grant/research support from: MSD, Roche, UCB, Novartis and Pfizer, Consultant for: MSD, Abbvie, Roche, UCB, Novartis, Pfizer and Abdi Ibrahim, Speakers bureau: MSD, Abbvie, Roche, UCB, Novartis, Pfizer and Abdi Ibrahim

DOI: 10.1136/annrheumdis-2019-eular.3374

THU0566

OCULAR FEATURES IN 381 PATIENTS WITH SYSTEMIC SARCOIDOSIS AND ITS CORRELATION WITH THE IWOS CRITERIA. STUDY IN A UNIVERSITY HOSPITAL

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Background: Sarcoidosis is a multisystemic inflammatory disease characterized by non-caseating epithelioid granulomas that can affect any organ system. The three most frequency affected organs are lung, skin and eyes. Ocular involvement is the presenting symptom in approximately 20-30% and can involve any part of the eye and its anexal tissues. Sarcoidosis may cause uveitis, conjunctivitis, episcleritis/scleritis, optical nerve disease and orbital inflammation.

Objectives: To analyze the prevalence of ocular involvement in systemic sarcoidosis, the clinical patterns and their correlation with the International Workshop on Ocular Sarcoidosis (IWOS) criteria. These criteria classify ocular sarcoidosis as definite, presumed, probable and possible, according to some ophthalmological and analytical findings. They are especially useful if a biopsy is not obtained or it is negative.

Methods: Retrospective study of patients admitted to a single reference University Hospital between 1999 and 2019 with diagnosis of sarcoidosis. Clinical findings, demographics features, anatomic location and IWOS intraocular signs were recorded. We also collected serum angiotensin

converting enzyme (ACE), liver enzyme test, chest radiography, chest computed tomography scan, treatment and biopsy if performed.

TABLE. Demographic and clinical features of the 50 patients with ocular sarcoidosis.

	Patients (n=50)
Age, mean (SD) years	45.5 (16.7)
Sex, men/women, n/n	23/27
Affected organs, n (%)	
Lung	30 (60)
Skin	14 (28)
Liver	4 (8)
Kidney	3 (6)
Musculoskeletal system	3 (6)
Central nervous system	3 (6)
Hearth	2 (4)
Ocular signs, n (%)	
Bilaterality	22 (44)
Snowballs/strings of pearls	19 (38)
Mutton-fat KPs	12 (24)
Multiple chorioretinal peripheral lesions	7 (14)
Periphelebitis	5 (10)
Anterior synechiae	1 (2)
Optic disc granulomas	1 (2)
IWOS criteria, n (%)	
Definite	22 (44)
Presumed	13 (26)
Possible	4 (8)
Treatment, %	
Prednisone (oral)	44 (88)
Methylprednisolone (bolus)	5 (10)
Conventional IS	
.....MTX	21 (42)
.....AZA	9 (18)
.....CsA	2 (4)
.....MMF	2 (4)
Biologic therapy	
.....IFX	5 (10)
.....ADA	4 (8)
.....GLM	2 (4)

Abbreviations: ADA, adalimumab; AZA, azathioprine; CsA, cyclosporine A; GLM, golimumab; IFX, infliximab; IS, immunosuppressor; KPs, keratic precipitates; MMF, mycophenolate mofetil; MTX, methotrexate; SD: standard deviation.

Results: We selected patients with ocular inflammation from a cohort of 381 patients with sarcoidosis (n=50, 13%). Most of the cases were women (54%) and median age was 45.5±16.7 years. In these 50 cases, the most affected organ was lung (60%), followed by skin (28%). Forty patients had uveitis, 32 of them with ocular symptoms. Thirty-nine out of 50 patients (78%) met one of the 4 IWOS diagnostic categories: 22 with definite (44%), 13 presumed (26%) and 4 with possible (8%) sarcoidosis. Eleven patients did not meet IWOS criteria. The most common ocular signs were bilaterality (44%), snowballs or strings of pearls (38%), mutton-fat KPs (24%), multiple chorioretinal peripheral lesions (14%) and periphelebitis (10%). The median value of ACE was 69 U/l. Forty-four patients (88%) received oral corticosteroids, 21 (42%) received methotrexate, 11 (21%) received another conventional immunosuppressor and 11 (21%) a biological treatment. TABLE shows demographic and clinical features.

Conclusion: In our population the IWOS Criteria had a sensitivity of 78%. Even though there is no gold standard for diagnosing ocular sarcoidosis yet, IWOS signs can help clinicians suspect it.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.4248

THU0567

POLYMYALGIA RHEUMATICA-LIKE SYNDROME FROM CHECKPOINT INHIBITOR THERAPY: CASE SERIES AND SYSTEMATIC REVIEW OF THE LITERATURE

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Background: Checkpoint inhibitor therapy has caused a paradigm shift in the field of oncology, producing significant survival benefits in patients with an ever-growing list of malignancies, but their use is attended by a spectrum of immune related adverse events (irAEs). Many rheumatic irAEs have been described. A critical and presently unanswered question is what proportion of these rheumatic irAEs represent new appearances of classic rheumatic diseases or, alternatively, represent new clinical variants with potentially different pathogenesis, clinical course and treatment responsiveness. Little is known about the PMR-like entity that has been described in the setting of ICI therapy.

Objectives: To assess whether the polymyalgia rheumatica (PMR)-like syndrome reported as an irAE from checkpoint inhibitor therapy is consistent with the 2012 EULAR/ACR provisional criteria for PMR¹.

Methods: The cases were derived from two sources. Group 1 represents reported cases from three contributing centers. Group 2 was derived from a systematic review of the literature searching for all cases reported as PMR or PMR-like illness associated with checkpoint inhibitor therapy. Cases were assessed for the quality of reporting and then analyzed to determine whether they fulfilled the 2012 EULAR/ACR provisional criteria for PMR.

Results: A total of 49 patients were included for analysis, including 9 cases from Cleveland Clinic (Table 1), 4 cases from Johns Hopkins University, and 7 cases from University Hospital of Bordeaux, in addition to the 29 separate cases found by systematic review. Among the entire group, 37 (75%) were designated "complete" indicating that they had sufficient data to reliably apply the 2012 EULAR/ACR criteria of which 28 (75%) cases fulfilled complete criteria for PMR. A number of cases also demonstrated some clinical features unusual for idiopathic PMR.

Conclusion: This study suggests a high proportion of reported cases of checkpoint inhibitor-related PMR fulfill preliminary criteria for PMR yet in one quarter clinical details were incomplete making verification problematic. Furthermore, in the absence of a gold standard for the diagnosis of PMR, the relationship of checkpoint inhibitor-related PMR to the idiopathic form remains unclear.

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Disclosure of Interests: cassandra calabrese Speakers bureau: Regeneron/Sanofi, Laura Cappelli Grant/research support from: Bristol-Myers Squibb, Consultant for: Regeneron/Sanofi Genzyme, Marie Kostine: None declared, Elizabeth Kirchner Consultant for: Celgene, Horizon, Novartis, Regeneron, Speakers bureau: Merck and Sanofi, Tawnie Braaten Grant/research support from: supported by T32 grant and "research reported in this publication was supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health under Award Number T32AR048522. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.", Leonard Calabrese Consultant for: Bristol-Myers-Squibb, Genentech and Astra-Zeneca.

DOI: 10.1136/annrheumdis-2019-eular.1389

THU0568

CLINICAL CHARACTERISTICS OF SEVEN RELAPSING POLYCHONDROITIS CASES MISDIAGNOSED AS ARTHRITIS

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Background: Relapsing polychondritis (RPC) is a rare autoimmune disease. It mainly affects the tissue abundant of cartilage, such as ear, nose, and tracheoles. The multiple systems including eye, joint, mucocutaneous, and kidney could be involved¹. As the presentation of arthritis was nonspecific and could appear in several connective tissue diseases,