including asymptomatic carriers, patients with systemic lupus erythematosus without history of thrombotic or obstetric APS, and non-pregnant women with a history of obstetric APS only. Recommendations for the management of thrombotic manifestations address different types of anticoagulation in patients with definite APS and first provoked or unprovoked venous thrombosis and the management of recurrent venous thrombosis, as well as the type and intensity of anticoagulation in patients with first or recurrent arterial thrombosis.

Recommendations for the management of obstetric APS describe the management of various types of pregnancy complications in APS and of refractory to treatment cases. Recommendations for catastrophic APS refer to precipitating factors, first-line treatment of catastrophic APS, and management of refractory cases.

Conclusion: These recommendations based on evidence and expert opinion aim to guide practice and improve quality of care in patients with APS.

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SP0192 UPDATE OF THE EULAR RECOMMENDATIONS LARGE VESSEL VASCULITIS MANAGEMENT

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Background: Since the publication of the European League Against Rheumatism (EULAR) recommendations for the management of large vessel vasculitis (LVV) in 2009, several relevant randomized clinical trials and cohort analyses have been published, which have the potential to change clinical care and therefore supporting the need to update the original recommendations.

Objectives: To update the 2009 EULAR recommendations for the management of LVV.

Methods: Using EULAR standardized operating procedures for EULAR-endorsed recommendations, the EULAR task force undertook a systematic literature review and sought opinion from 20 experts from 13 countries. We modified existing recommendations and created new recommendations.

Results: Three overarching principles and 10 recommendations were formulated. We recommend that a suspected diagnosis of LVV should be confirmed by imaging or histology. High dose glucocorticoid therapy (40-60 mg/day prednisone-equivalent) should be initiated immediately for induction of remission in active giant cell arteritis (GCA) or Takayasu arteritis (TAK). We recommend adjunctive therapy in selected patients with GCA (refractory or relapsing disease, presence of an increased risk for glucocorticoid-related adverse events or complications) using tocilizumab. Methotrexate may be used as an alternative. Non-biologic glucocorticoid-sparing agents should be given in combination with glucocorticoids in all patients with TAK and biologic agents may be used in refractory or relapsing patients. We no longer recommend the routine use of antiplatelet or anticoagulant therapy for treatment of LVV unless it is indicated for other reasons.

Conclusion: We have updated the recommendations for the management of LVV to facilitate the translation of current scientific evidence and expert opinion into better management and improved outcome of patients in clinical practice.

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SATURDAY, 15 JUNE 2019

12:00:00 – 13:30:00

Skin and eye manifestations in rheumatic diseases.

SP0193 WIN: SKIN AND RHEUMATIC DISEASES

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Background: The main underlying mechanisms of skin manifestations in rheumatic diseases include autoimmune responses, auto-inflammatory processes, and tissue-specific alterations. In psoriasis, therapies targeting T cell activation, T cell migration, or neutralization of disease-related cytokines are highly effective. However, targeted therapies still need to be developed in less frequent autoimmune diseases, such as systemic lupus erythematosus (SLE), systemic sclerosis (SSc), or dermatomyositis (DM).

Objectives: To provide an update for rheumatologists on the management of skin manifestations in autoimmune diseases based on recent insights into the pathogenesis.

Methods: Several agents are approved for the treatment of SLE, including the monoclonal antibody belimumab, a B lymphocyte stimulator-specific inhibitor, but no drugs have been licensed specifically for the treatment of skin manifestations in this disease. The aim of the European guideline was to achieve a broad consensus on treatment strategies for patients with cutaneous lupus erythematosus (CLE) by a European subcommittee. In total, 16 European participants were included in this project and agreed on all recommendations.

Results: First-line treatment options in CLE include topical corticosteroids or calcineurin inhibitors; in patients with disfiguring and widespread disease, systemic agents need to be applied. The first-line systemic treatment is antimalarials, but some patients are therapy-resistant and immunosuppressive agents, such as methotrexate, are used as alternative therapeutic option. In 2011, the monoclonal antibody belimumab was introduced for SLE as an adjunct therapy for patients with autoantibody-positive disease who despite standard therapy show high disease activity, intolerance of other treatments, or an unacceptably high need for corticosteroids. So far, a validated skin score has not been used to confirm the efficacy of belimumab on mucocutaneous manifestations. In SSc, the therapeutic modalities are even more limited. Treatment with endothelin-receptor antagonists has been proven to reduce the occurrence of new digital ulcers in SSc patients but has no or limited effect on healing of digital ulcers. DM is a further idiopathic autoimmune disease characterized by inflammation of the muscles and skin, which is treated with immunosuppressives. Corticosteroids are still the first-line treatment for muscle involvement in DM, but skin lesions often flare by reduction or discontinuation.

Conclusion: In summary, there is a high unmet need for new therapeutic strategies focusing on skin involvement in systemic autoimmune diseases. Therefore, innovative designs of randomized controlled trials based on the pathogenesis are warranted to develop new therapies for patients with skin manifestations in rheumatic diseases.

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SATURDAY, 15 JUNE 2019

12:00:00 – 13:30:00

To image or not to image in spondyloarthritis?_____

SP0194 WHEN AND HOW TO USE AND NOT USE IMAGING FOR DIAGNOSIS?

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Since axial spondyloarthritis (axSpA) has no single shared distinguishing feature that distinguishes the disease from other causes of back pain, diagnosis of axSpA requires recognition by the clinician of a pattern of features that taken together are characteristic of axSpA. Information from patient history and physical examination, laboratory, and imaging findings may all aid in recognition of axSpA and the diagnosis of axSpA requires exclusion of other potential causes for these abnormalities/differences.

Traditionally, plain radiography is used to assess sacroiliac and spinal involvement of disease. A weakness of radiography in assessing sacroiliac involvement - apart from its inability to detect early disease - is reader variability. Additionally, involvement of the spine (i.e. detection of syndesmophytes) is very uncommon in early disease.

The use of MRI in diagnosing axSpA has increased over the past ten years and MRI greatly facilitates earlier diagnosis of axSpA. However, it has also become increasingly clear that MRI detectable lesions associated with SpA - including bone marrow edema and fatty lesions - may also occur in patients without axSpA.