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

Annegret Kuhn. *University Hospital Muenster, Executive Department of the University Hospital, Muenster, Germany*

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.

The aim of this presentation is to provide insight into the pitfalls of imaging in diagnosing SpA, with a particular focus on false positives in imaging as well as the importance of interpretation of the clinical context.

Disclosure of Interests: None declared

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SP0195 IMAGING IN DISEASE AND TREATMENT MONITORING – DOES IT MATTER?

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Background: Imaging of the axial skeleton is a crucial step in classification and diagnosis of axial Spondyloarthritis. After diagnosis, patients with axSpA are being treated with non-steroidal anti-inflammatory drugs (NSAIDs) or with disease-modifying anti-rheumatic drug (bDMARD). Despite the fact, that the latter treatment is referred to as disease-modifying and modification of the disease is supposed to be relating to the objective course of the disease, as assessed by imaging, recommendations for monitoring of the course of axSpA by imaging are still lacking mostly due to the lack of data. Nevertheless, this aspect is mentioned in the treat-to-target principle for axSpA. Overall, earlier data have shown that the course of lesions documented by magnetic resonance imaging (MRI) is correlating well with other objective measures of changes of systemic inflammation such as c-reactive protein (CRP), than with patient-reported measures of disease activity. Similarly, conventional radiographs (CR) are being used for documenting of the development of structural changes over many years.

Objectives: The objective of this presentation is to show the current evidence of the possibilities of different imaging techniques used in axSpA for assessment of the course of the disease (both for the inflammatory and chronic changes) and give practical tips about when imaging would be advised for monitoring the disease course or where this can be avoided.

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SP0196 IS THERE ROOM FOR OTHER IMAGING MODALITIES BEYOND CONVENTIONAL X-RAYS AND MRI?

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Early diagnosis of spondyloarthritis is still tempting since objective measures to assess disease activity are often negative. MRI provides highly sensitive visualization of inflammation, but detection levels in early spondyloarthritis are varying. Another clinical temptation is early treatment evaluation of spondyloarthritis. An important outcome measure is therapeutic efficacy on bone formation in vertebral column and sacro-iliac joints. Conventional X-rays only allow for assessment of bone formation over a time span of at least 2 years. In this presentation, opportunities with new upcoming imaging techniques to address above mentioned clinical issues will be discussed in relation to longer existing imaging techniques.

Disclosure of Interests: None declared

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SATURDAY, 15 JUNE 2019

12:00:00 – 13:30:00

The lung in rheumatoid arthritis

SP0197 CASE 1 PRESENTER: EARLY RA WITH LUNG PROBLEMS IN THE CONTEXT OF BIOLOGICAL TREATMENT

Ana Milena Millán Arciniegas. Santa Creu i Sant Pau Hospital, Rheumatology, Barcelona, Spain

We present a 77-year-old male patient with a history of former smoker, arterial hypertension and dyslipidaemia, whose diagnosis of Rheumatoid Arthritis was made in July 2017 by arthritis of metacarpophalangeal joints, wrists and knees and positivity for anticyclic citrullinated peptide antibodies (ACPA) and rheumatoid

factor (RF). Treatment with Methotrexate and prednisone was started but the patient did not achieve adequate control of joint symptoms, so we decided to add Etanercept to the treatment. A good joint response was obtained but in a follow-up control he explained breathlessness with cough and low grade fever. The chest X-Ray was not conclusive and we decided to perform a high resolution computerized tomography (HRCT) scan. An interstitial involvement was detected and an accurate differential diagnosis was made.

Disclosure of Interests: None declared

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SP0198 CASE 1 DISCUSSANT: HOW TO DIFFERENTIATE ILD FROM OTHER CAUSES OF LUNG INVOLVEMENT IN RA

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The lung in Rheumatoid Arthritis (RA) can be affected by different manifestations and Interstitial Lung Disease (ILD) related to RA is one of the most devastating complications that we can find in the disease. The lung parenchyma involvement can be present with different patterns. As opposite with other forms of connective tissue diseases the usual interstitial pneumonia pattern (UIP) is more frequent than nonspecific interstitial pneumonia pattern (NSIP) in RA. Currently high-resolution computed tomography (HRCT) and pulmonary function test are the best tools to detect and to follow ILD in RA. Nevertheless, other lung involvements, infections and drug toxicity of nonbiological and biological disease-modifying anti-rheumatic drugs (DMARDs) can affect patients with rheumatoid arthritis and simulate ILD. To know which affection are present in our patients with interstitial lung compromise is crucial to proceed against the problem. Patient characteristics, clinical presentation, radiological distribution or bronchoalveolar lavage would be helpful to discriminate ILD from other causes of lung involvement. An individual and multidisciplinary approach is very important to do the best management in these patients.

Disclosure of Interests: None declared

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SP0199 CASE 2 DISCUSSANT: HOW TO TREAT DIFFICULT ILD

Toby Maher. Imperial College London and Royal Brompton Hospital, National Heart and Lung Institute, London, United Kingdom

Background: ILD frequently results in progressive and irreversible destruction of the lung through scarring. Prompt therapy can help rescue lung function and prevent subsequent respiratory decline. This case will demonstrate the challenges inherent in diagnosing and managing interstitial lung disease in the context of connective tissue disease

Objectives: To discuss typical presentation of CTD-ILD

Review challenge of making diagnosis and choosing best treatment.

Assess treatment options, duration of therapy and measurement of treatment response.

Conclusion: A range of therapeutic options exist for CTD-ILD albeit with a paucity of trial data to support best practice. Accurate diagnosis of systemic disease, paired with careful assessment and monitoring of the respiratory system are vital in ensuring optimal management. Intravenous therapy is often necessary in advanced disease or for disease which proves refractory to oral immunosuppression.

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