	ONCO diagnosis	ONCO treatment	time	OPH diagnosis	Toxicity (G)	OPH treatment	ICI withdrawal	Prognosis	Other toxicities
♂ 79	Melanoma BRAF wt+ retroperitoneal mtt	Pembrolizumab x7 Ipilimumab x2	6m 6w	Bilateral AU with synechia	2	Prednisone 1 mg/kg + Topical Topical	Temporal	No inflammation without treatment VA Preserved Synechia	Transaminitis G2 Asthma G2
♂ 85	Cáncer de vejiga localizado avanzado	Atelizumab x7	5m	Bilateral AU	2		Definitive	No inflammation without treatment VA Preserved	PMR G2 Thyroiditis G1 Transaminitis G1 Mucositis G1
♂ 45	Melanoma BRAF mutant (retropectoral mass)	Pembrolizumab x5	4m	Bilateral Panuveitis with synechia + papilledema	3	Prednisone 0,5 mg/kg + topical	Definitive	No inflammation without treatment VA Preserved	None
♂ 47	Melanoma BRAF wt (abdominal mass +peritoneal mtt + adrenal mtt)	Nivolumab x2 Ipilimumab x1	2m 1m	Bilateral Panuveitis with synechia + papilledema	3	Prednisone 0,5 mg/kg + topical	Nivolumab temporal Ipilimumab definitive	No inflammation without treatment VA Preserved	Rash G1 Pruritus G1 Vitiligo

Conclusion: Uveitis is an infrequent, although potentially serious, immune-mediated side effect of ICI. Early recognition, discarding other causes of uveitis, particularly the masquerade syndrome, and early intervention are key to a good prognosis. The collaboration between the oncology teams and the ocular inflammation units must be close to establish the correct diagnosis and treatment, as well as to decide individually on the reintroduction or not of the oncological treatment. The implementation of registers on the adverse effects of these drugs can help to dimension the problem more accurately.

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FRI0591

RHEUMATIC IMMUNE-RELATED ADVERSE EVENTS ASSOCIATED WITH TREATMENT WITH IMMUNE CHECKPOINT INHIBITORS: A CASE SERIES FROM TWO REFERRAL CENTRES

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Background: Immune checkpoint inhibitors (ICI) against CTLA-4 or PD-1/PD-L1 improve the survival of patients with advanced malignancies including melanoma, lung cancer among other tumours. Because of its mechanism of action, ICI are prone to produce different immune-related adverse events (irAEs), including musculo-skeletal manifestations.

Objectives: Our aim was to describe the experience with rheumatic irAEs in two tertiary centres.

Methods: All adult patients referred to the Rheumatology department from 2015 to 2018 because of the onset of musculo-skeletal symptoms following treatment with an ICI were included. Data collected comprised demographic features as well as ICI indication and type, history of rheumatic disease, disease manifestations at irAE onset, laboratory tests, ultrasound findings and treatment. Diagnostic and treatment approach was done according clinical judgment and in a daily clinical practice setting.

Results: 20 patients were included, 50% female, with a mean age of 61,5 years (range 32-83). The indication for ICI was melanoma in 10 cases, lung cancer in 5, urothelial neoplasia in 2 and squamous skin, breast and head and neck cancer in 1 case each. Pembrolizumab was the most used ICI accounting for 9 cases (1 combined with epacadostat), 8 patients were treated with Nivolumab (4 combined with Ipilimumab), 2 with Atezolizumab (1 combined with Ibatasertib) and 1 Ipilimumab in monotherapy.

A history of previous rheumatic disease was reported in 8 patients (1 seropositive RA, 1 Spondyloarthritis, 1 SLE, 1 gout, 1 chondrocalcinosis, 1 fibromyalgia, 1 De Quervain tendinitis, 1 hand osteoarthritis) and 1 had psoriasis.

The most frequent irAE presentation was arthritis with 8 cases (40%), arthralgia in 4 cases (20%), 1 case of myalgia, 2 presented PMR-like symptoms, 1 tenosynovitis and 2 paraesthesia (1 with associated dysesthesia).

After assessment, 7 patients were diagnosed as undifferentiated arthritis, 1 leukocytoclastic vasculitis, 1 small-vessel vasculitis, 2 psoriatic-like arthritis, 1 tenosynovitis, 2 PMR and 6 were classified as having non-inflammatory symptoms.

Antibody status was analyzed in 16 patients. Anticardiolipin-peptide antibodies, rheumatoid factor and HLA B27 were negative in all cases (except for 1 patient with seropositive RA), ANAs were positive in 4 (including 1 patient with previous SLE) but without any specificities (i.e. ENAs) and ANCA were negative in one case with small-vessel vasculitis. Ultrasound assessment was performed in 6 patients, 3 presented synovial hypertrophy with positive power Doppler (1 with tenosynovitis associated), 1 peritendinous fluid collection, 1 elbow joint effusion and 1 bilateral supraspinatus calcified tendinopathy.

Most patients were treated with glucocorticoids 12 (60%) and NSAID 6 (30%) and only 3 patients had to discontinue ICI treatment due to irAEs.

Conclusion: Our results were in line with previous studies showing that musculo-skeletal irAEs associated to ICI may present as a flare of a previous known rheumatic disease or as a de novo symptom. Most patients presented with asymmetric mono or oligoarthritis having a good response to GC and NSAID without the need of adding DMARD or withdraw of ICI therapy.

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CLINICAL CHARACTERISTICS OF OLDER AGE-ONSET BEHÇET SYNDROME PATIENTS

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Background: The usual onset of Behçet syndrome (BS) is in the 3. decade. Older age-onset defined as fulfilling the ISG criteria after 40 years of age is rare. One study from our center had reported the severity of eye disease was not different between early onset (≤ 24 years) and late onset (≥ 25 years) group. (1). While there is ambiguity in the definition of older onset, a few case series (2,3) coming mostly from ophthalmology or dermatology settings describe a similar or less severe clinical picture among late onset patients (pts) compared to early onset.

Objectives: To evaluate clinical characteristics of older onset pts and to compare them with classic onset pts.