The most commonly (58.5%) used imaging method for diagnosis was computed tomography (CT). All the patients used initial glucocorticoid treatment. A patients (7.5%) received only glucocorticoid, others were underwent the following treatments combined with glucocorticoid: azathioprine (AZA) (60.4%); methotrexate (mtx) (11.3%); rituximab (RTX) + AZA (9.4%); mtx + AZA (5.7%); RTX (3.8%) and infliximab (1.9%).

In the follow-up, a significant decrease in acute phase reactants was found in 62% of the patients at their last visits. While 27.3% of the patients had complete remission, 38.4% had partial remission, 20.5% had stable course, 13.6% had progression in the disease and 2.3% had recurrence. In 18 patients (63.3%) out of 28 patients who were in partial or complete remission, remission was achieved by using glucocorticoid and AZA combination treatment.

Conclusion: In conclusion, we have described a considerably large series of patients with IgG4-related disease from Turkey. The results of the study suggested that AZA and glucocorticoid combination treatment was commonly used in Turkish patients with IgG4-related disease and it might be a good treatment option to achieve remission.

REFERENCES:

Disclosure of Interests: None declared


FR0597 A SYSTEMATIC REVIEW OF THE EFFECTIVENESS AND SAFETY OF PHARMACOLOGICAL TREATMENTS IN PATIENTS WITH SYSTEMIC IDIOPATHIC JUVENILE ARTHRITIS (SJIA)

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Background: Treatment options for SJIA include canakinumab, tocilizumab (both approved by US FDA and EMA) and anakinra (approved by EMA), while anti-tumor necrosis factor inhibitors, steroids, disease-modifying anti-rheumatic drugs and non-steroidal anti-inflammatory drugs are also used.1 In a recent systematic review included only randomized controlled trials (RCTs) of biologics. We aimed to generate a more comprehensive evidence on the effectiveness and safety of treatments used in SJIA.

Objectives: To assess evidence on the effectiveness and safety of therapeutic agents for SJIA from RCTs and real-world studies.

Methods: A systematic literature review was conducted using Cochrane methodology2 from 2000 to Jan 2018. Sources included Embase®, MEDLINE®, MEDLINE® in Process and Cochrane library. Studies were searched for English language publications as full-text articles (2000 to 2018) or conference abstracts (2015 to Jan 2018). Studies with <15 pts were excluded.

Results: Of the 62 included studies, 8 were RCTs and 54 were real-world studies. The interventions included in the RCTs were anakinra (ANA), canakinumab (CAN), etanercept (ETN), methotrexate (MTX) and tocilizumab (TCZ) (1 RCT each and 1 withdrawal trial for TCZ), and 2 RCTs for rilonacept (RLN); all vs. placebo (PLB). In addition to the interventions mentioned in the RCTs, real-world studies also included other interventions such as abatacept, adalimumab (ADA), infliximab (INF), non-steroidal anti-inflammatory drugs and steroids. Juvenile idiopathic arthritis - inactive disease of rheumatology (JIA ACR)-30 was the most common composite outcome reported across studies.

In RCTs, the JIA ACR-30 (+ no fever) responses were significantly superior to PLB for CAN (81% vs. 10%), TCZ (85% vs. 24%), and ANA (92% vs. 50%) (p<0.05 for all), while other interventions (RLN and MTX) were less responsive. Additionally during the trial extension period, the inactive disease rates were 57%, 31% and 31% for TCZ, CAN and ANA respectively.

In real-world studies, the JIA-ACR 30 response rates reported for ANA, CAN or PLB (patients were on either therapy), TCZ and ETN were 50%-55%, 57%-60%, 47%-100% and 47%-73% at short-term follow-up.