Table 1. Albumin and LDH, and associations to oncological response and rheumatic irAE development

	Oncological non-responders	Oncological responders	p-value
Albumin (g/L)	33.4	35.2	< 0.001
LDH (units/L)	262	237	0.16
	No rheumatic irAE	Rheumatic irAE	p-value
Albumin (g/L)	34.0	34.9	0.41
LDH (units/L)	254	238	0.57

Disclosure of Interests: None declared

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FRI0603 SARCROIDOSIS IN A TERTIARY HOSPITAL

Isabel Madroñal García, Clara Aguilera Cros, Maria Dolores Arcila Duran, Lara Mendez, Marina Gomez Vargas, Alberto Ruiz Roman, Ricardo Juan Gil Velez, Jose Antonio Rodriguez Portal, Noemi Patricia Garrido Puñal, Esteban Rubio Romero. *Hospital Universitario Virgen del Rocío, Reumatología, Sevilla, Spain*

Background: Sarcoidosis (S) is a systemic granulomatous disease of unknown etiology. The most frequent affectation is pulmonary, ocular and cutaneous, although sarcoidosis can damage other organs, such as the musculoskeletal system.

Objectives: To describe the clinical characteristics and the radiological pattern, in a cohort with predominant pulmonary S, as well as to establish the relationship between the angiotensin converting enzyme (ACE) levels and the S course (chronification or remission).

Methods: This is a retrospective descriptive study of patients treated in our hospital, since 2008 to 2018, with diagnosis of S. The data was obtained through the review of medical records. The delay in the diagnosis of S was defined as the difference in months between the initial diagnostic suspicion and the final diagnosis of S.

We use Chi-square tests to study the association between ACE levels and the course of the disease.

Results: Fifty-five patients (31 women) were included, with a mean age of 52 ± 12 years. The first diagnosis was: 85% S, 10% lymphoma and 4% tuberculosis. The median of months for the definitive diagnosis of S was 5.5 months.

Extrapulmonary clinical manifestations in table 1.

The ACE is increased in 38 patients (70%). Simple x-ray and high resolution tomography of chest were done in all patients. Pulmonary stage 2 was the most frequent (51%), followed by stage 3 (16%), stage 0 (14%) and stage 4 (9%).

In 90% of the patients, histological confirmation was obtained by trans-bronchial (47%), cutaneous (11%) or lymph node biopsy (29%).

94% of the patients have been treated with oral glucocorticoids, 52% associate immunosuppressive therapy (Methotrexate 27% and Azathioprine 14%) or biological treatment (1 patient with Adalimumab and another with Infliximab). In 54% of the patients the S had a chronic course and in 43% S remitted.

Increased levels of ACE were associated with clinical remission of the disease and normal levels with chronicity (p: 0.013).

EXTRATHORACIC CLINICAL MANIFESTATIONS	N(%)
Skin	15(27)
Neurological	4(7)
Cardiac	8(14)
Renal	2(4)
Ocular	7(13)
Monoarthritis	3(5)
Poliarthritis	6(11)
Bilateral swelling in ankles	6(11)
Hepatosplenomegaly	8(14)

Conclusion: The results of our study resembles, in general, what has been published in the literature. In our study, elevated ACE is associated with remission of the disease, contrary to the published, in which increased levels of ACE in symptomatic patients may reflect disease activity.

Disclosure of Interests: None declared

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FRI0604

SYSTEMIC SARCROIDOSIS. STUDY OF 381 PATIENTS FROM A TERTIARY UNIVERSITY HOSPITAL IN THE NORTH OF SPAIN

José Luis Martín-Varillas¹, Lara Sánchez Bilbao¹, Iñigo González-Mazón¹, Raúl Fernández Ramón², D. Prieto-Peña¹, David Martínez-Lopez¹, Eva Peña Sainz-Pardo³, Belén Atienza-Mateo¹, Monica Calderón-Goercke¹, Rosalía Demetrio-Pablo², Vanesa Calvo-Río¹, Miguel A. González-Gay¹, Ricardo Blanco¹. ¹H.U.M. Valdecilla, Rheumatology, Santander, Spain; ²H.U.M. Valdecilla, Ophthalmology, Santander, Spain; ³H.U.M. Valdecilla, Paediatrics, Santander, Spain

Background: Sarcoidosis is a systemic granulomatous disease characterized by the presence of non-necrotizing granulomas in different parenchyma.

Objectives: To describe demographic, clinical and analytical features in a cohort of patients with Sarcoidosis diagnosis from northern Spain during the last twenty years.

Methods: Descriptive study of 381 patients diagnosed with sarcoidosis during the period 01/01/1999 to 01/01/2019. Biopsy and/or clinical and compatible imaging tests were required for the diagnosis of sarcoidosis. Demographic parameters, clinical manifestations, complementary tests and treatment were registered. Results are expressed as mean±SD or as median and interquartile range (IQR) as appropriate.

Results: 381 patients (192 female/191 male, ratio 1:1), with a mean age 45.5±15.4 years at disease onset, and with 94.8% of Spanish nationality. 33% were smokers at diagnosis and 6.3% had tuberculosis (Table 1). The sarcoidosis incidence rate in our population was 3.3 cases/100000 p/year, similar to other national series¹.

Most frequent clinical manifestations were as follow: pulmonary symptoms (72.3%), general symptoms (37.3%), skin involvement (31%), joint manifestations (27.9%), ophthalmological manifestations (13.0%), digestive disorders (9.3%), neurological symptoms (6.5%), nephrological (4.7%) and cardiological involvement (1.6%) (Table 1). In addition, 11.5% of the patients had a Löfgren syndrome, 0.5% a Heerfort syndrome and up to 11.5% had mediastinal adenopathy as an incidental finding in simple chest radiography.

A simple chest radiograph was performed in all patients. 83.7% presented abnormal patterns: stage I (41.4%), stage II (32%), stage III (7.6%) and stage IV (3.8%). In addition, 29.9% and 10.5% of patients presented pathological scintigraphy and PET respectively. Biopsy was performed in 81.9%, with a mediastinal approach in 43.3% (Table 2).

After a median follow-up of 11.0 [6.0-17.0] years, we observed that up to 32% of patients never received treatment. In the remaining 68%, the main treatment was oral glucocorticoids with a mean dose of 43.4±19.1 mg/day. Other treatments used were conventional immunosuppressants and biological agents (table 2).

Table 1.

	Patients diagnosed with sarcoidosis (N=381)
DEMOGRAPHIC PARAMETERS	
Sex, n (%)	191 (50.1) / 190 (49.9)
Age at disease onset (years), mean ± SD	45.5 ± 15.4
Current age (years), mean ± SD	59.0 ± 16.3
Follow-up, median [IQR]	11.0 [6.0-17.0]
Nationality (Spanish), n (%)	363 (94.8)
Smokers, n (%)	126 (33.1)
Asthma, n (%)	24 (6.3)
Tuberculosis, n (%)	24 (6.3)
Tumours, n (%)	23 (6.0)
CLINICAL MANIFESTATIONS	
Pulmonary symptoms, n (%)	277 (72.3)
- Dyspnea, n (%)	103 (26.8)
- Cough, n (%)	35 (9.1)
- Pleuritic pain, n (%)	10 (2.6)
- Adenopathy, n (%)	129 (33.7)
Ocular involvement, n (%)	50 (13.0)
- Uveitis, n (%)	36 (9.4)
- VKA, n (%)	5 (1.3)
- Exophthalmos, n (%)	2 (0.5)
- Others, n (%)	7 (1.8)
Skin involvement, n (%)	119 (31.1)
- Erythema nodosum, n/N (%)	72 (18.8)
- Lupus pernio, n/N (%)	7 (1.8)
- Parotid gland hypertrophy, n/N (%)	7 (1.8)
- Granulomatous dermatitis, n/N (%)	33 (8.6)
Joint involvement, n (%)	107 (27.9)
- Arthralgia, n (%)	66 (17.2)
- Arthritis, n (%)	40 (10.4)
- Sarcoidosis myopathy, n (%)	1 (0.3)
Digestive disorders, n (%)	36 (9.3)
- Hypertransaminasemia, n/N (%)	20 (5.2)
- Hepatic granulomas, n/N (%)	13 (3.3)
- Other granulomas, n/N (%)	3 (0.8)
Neurological symptoms, n (%)	25 (6.5)
- Headache, n (%)	13 (3.5)
- Meningitis, n (%)	2 (0.5)
- Neuropathy, n (%)	6 (1.5)
- Others, n (%)	4 (1.0)
Cardiological manifestations, n (%)	6 (1.6)
- Dilated cardiomyopathy, n (%)	4 (1.0)
- Pericarditis, n (%)	1 (0.3)
- SMI, n (%)	1 (0.3)
Nephrological manifestations, n (%)	18 (4.7)
- Acute renal failure, n (%)	12 (3.1)
- Chronic kidney disease, n (%)	5 (1.3)
- Lithiasis, n (%)	1 (0.3)
Systemic symptoms, n (%)	143 (37.3)
- Fever, n (%)	36 (9.4)
- General syndrome, n (%)	107 (27.9)
Lymphadenopathy as incidental finding, n (%)	44 (11.5)
Löfgren syndrome, n (%)	44 (11.5)
Heerfort syndrome, n (%)	2 (0.5)

Table 2.

	Patients diagnosed with sarcoidosis (N=381)
LABORATORY TESTS	
CRP (mg/dl), median [ICR]	0.2 [0.0-1.2]
ESR (mm/1h), median [ICR]	22.0 [10.0-38.0]
ACE, mean±SD	78.7 ± 46.2
Calcium, mean±SD	9.4 ± 0.9
Thrombocytosis, n (%)	9 (2.4)
Lymphopenia, n (%)	43 (11.3)
Hypercalciuria, n (%)	29 (7.6)
CD4/CD8 > 3.5, n (%)	122 (32.0)
IMAGING TESTS	
Patients with abnormal radiological patterns:	319 (83.7)
- Stage I, n/N (%)	156 (41.4)
- Stage II, n/N (%)	122 (32)
- Stage III, n/N (%)	29 (7.6)
- Stage IV, n/N (%)	14 (3.8)
Confirmed lymphadenopathy in CT, n (%)	300 (78.7)
Pathological scintigraphy, n (%)	114 (29.9)
Pathological PET, n (%)	40 (10.5)
Non-caseating granulomas in biopsy, n (%)	290 (75.7)
- Mediastinum, n (%)	166 (43.3)
- Lung, n (%)	67 (17.5)
- Liver, n (%)	9 (2.4)
- Skin, n (%)	45 (11.7)
- Lymphadenopathy, n (%)	3 (0.8)
TREATMENT	
Not treated, n (%)	122 (32.0)
Glucocorticoid treatment	
- Topical treatment, n (%)	39 (10.2)
- Prednisone, n (%) / mean dose (mg/day), mean±SD	206 (54.1) / 43.4±19.1
- Bolus MTP, n (%)	15 (3.9)
Conventional immunosuppressants	
- Methotrexate, n (%) / mean dosage (mg/week), mean±SD	53 (13.9) / 15.4±5.5
- Azathioprine, n (%) / mean dosage (mg/day), mean±SD	17 (4.5) / 91.6±32.2
- Cyclophosphamide, n (%)	2 (0.5)
- Mycophenolate mofetil, n (%)	2 (0.5)
Biological agents	
- Infliximab, n (%)	14 (3.7)
- Adalimumab, n (%)	19 (5.0)
- Etanercept, n (%)	1 (0.3)
- Golimumab, n (%)	2 (0.5)
- Tocilizumab, n (%)	3 (0.8)
- Rituximab, n (%)	3 (0.8)
- Secukinumab, n (%)	1 (0.3)

Conclusion: Results obtained were similar to other national and international series, with the exception of non-predominance of female sex and the highest percentage of ocular involvement in our study. Currently, biological treatment (especially anti-TNF-alpha) is used more frequently.

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FRI0605 EFFECTIVENESS AND SAFETY OF OFF-LABEL USE OF TOCILIZUMAB IN AUTOIMMUNE DISEASES : A MULTICENTER STUDY IN INTERNAL MEDICINE DEPARTMENTS

Martin Michaud¹, Thomas Sene², Pascal Chazeraï², Olivier Lidove², Geoffrey Urbanski³, Frederique Retornaz⁴, Boris Bienvenu⁵, Laurent Chiche⁴, Florian Catros¹, Laurent Sailer⁶, Laurent Alric⁶, Jean Thomas Giraud⁷, Léo Caudrelier⁸, Slim Lassoued⁸, Sophie Ancellin¹, Francis Gaches¹. ¹Joseph Duclung Hospital, Internal Medicine, Toulouse, France; ²Croix Saint Simon Hospital, Paris, France; ³Angers University Hospital, Internal Medicine, Toulouse, France; ⁴Hopital Européen, Internal Medicine, Marseille, France; ⁵Saint Joseph Hospital, Internal Medicine, Marseille, France; ⁶Toulouse University hospital, Internal Medicine, Toulouse, France; ⁷Tarbes Hospital, Internal Medicine, Tarbes, France; ⁸Cahors Hospital, Internal Medicine, Cahors, France

Background: Tocilizumab (TCZ) is a recombinant humanized anti-interleukin-6 receptor monoclonal antibody. There is increasing evidence of TCZ efficacy in refractory auto-immune diseases.

Objectives: To describe off-label use, efficacy and tolerance of TCZ use in Internal Medicine Departments.

Methods: This is a retrospective, descriptive and multicenter study from 9 departments of Internal Medicine. Data were reported using a standardized case report file in January 2019.

Results: Fifty one patients were included (19 men, 32 women). Mean age was 55.6 ± 17 years (range 23 - 80). TCZ was used in:

- 12 connective tissue diseases (23.5%): relapsing polychondritis (n=6), systemic sclerosis (n=3), anti-synthetase syndrome (n=1), and unclassified connective tissue disease (n=3).
- 10 vasculitis (19%): Takayasu arteritis (n=7), Cogan disease (n=1), pan-arteritis nodosa (n=1), unclassified vasculitis (n=1).
- 10 ophthalmologic conditions (19%): non infectious posterior uveitis (n=8), sympathetic ophthalmia (n=1), Basedow orbitopathy (n=1).
- 8 adult-onset Still's diseases (16%).
- 5 cases of polymyalgia rheumatica (10%).
- 3 miscellaneous diseases (6%): idiopathic AA amyloidosis, multicentric non HHV8 Castlemann disease, Erdheim Chester disease (1 case each).

Mean disease duration was 7.5 ± 6.4 years. In 44 cases (86%) TCZ was administered for refractory disease to corticosteroids and immunosuppressive drugs. Previous therapies included corticosteroids (83%), methotrexate (66%), TNF inhibitor drug (44%), azathioprine (20.8%), mycophenolate (12%), cyclophosphamide (8%), rituximab (10%), hydroxychloroquine (6%), anakinra in 2 patients and interferon, dapsone, etoposide, leflunomide, abatacept, salazopyrin or intra-venous immunoglobulin in 1 patient each.

TCZ was initiated as first-line therapy (15.5%), second-line therapy (17.5%), third-line therapy (31%), fourth-line therapy (19%), fifth-line therapy (14%), sixth-line therapy (12%) or as seventh line therapy in one case. TCZ was associated with methotrexate in 3 cases (6%). Treatment route was intravenous (96%).

At the end of the follow up, 41 patients (80%) were still using TCZ, with a mean follow up period of 22 ± 23 months (range 1-90). In these patients, daily corticosteroid use significantly decrease from 16.5 ± 18 mg to 5.7 ± 13.7 mg (p<0.005, using paired T test). Considering the 28 patients using TCZ since more than 6 months, short term efficacy was 93% (2 cases of loss of efficacy).

TCZ was interrupted in 10 patients (19%), because of treatment failure (n=2), loss of efficacy (n=2) or side effect (n=6). Side effects were infection (2 pneumonias, zona, sinus infection), pruritus (n=1), urticaria (n=1), dyslipidemia (n=1), high blood pressure (n=2), infusion-related reaction (n=1), bullous dermatitis (n=1), acute renal failure (n=1), angioedema (n=1), mouth ulcers (n=1).

Conclusion: TCZ is used in various autoimmune diseases. TCZ allowed a significant corticosteroids reduction and short term efficacy was 93% in patients using TCZ for more than 6 months. Nevertheless TCZ was interrupted in 19% of the patients. TCZ use will probably be more common in the future to treat refractory autoimmune diseases.

Disclosure of Interests: None declared

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FRI0606 AUTOIMMUNE MANIFESTATIONS IN A COHORT OF PATIENTS WITH TYPE 1 DIABETES MELLITUS

Andrea Monroy Calero. Tenerife, Reumatología, San Cristóbal De La Laguna, Spain

Background: Type 1 diabetes mellitus (T1D) is an organ-specific autoimmune disease characterized by the presence of circulating, islet-specific, pancreatic auto-antibodies against glutamic acid decarboxylase (GAD65) and the destruction of insulin-producing pancreatic beta cells. An increased risk of developing other serological manifestations and autoimmune diseases has been described, mainly of the thyroid (20% with antithyroid antibodies) and celiac disease (5%). In addition, it has also been described in association with Addison's disease, autoimmune polyglandular syndrome, psoriasis and other systemic autoimmune comorbidities diseases such as rheumatoid arthritis (RA), systemic juvenile idiopathic arthritis and Sjogren's syndrome. It also has been suggested that T1D might have a genetic factor, pathogenic pathways with pleiotropic effects, and cytokines such as interferon type I, among others.

Objectives: 1) Study the prevalence of autoimmune comorbidities in patients with T1D. 2) Describe the clinical-immunologic profiles of these patients.

Methods: A descriptive, retrospective study of a cohort of patients diagnosed with T1D, according to ADA (American Diabetes Association), follow-up by Endocrinology and Rheumatology Units of a 3rd level hospital from June 1975 to July 2018. Clinical and analytical-immunologic