Objectives: We aimed to evaluate the drug retention rates, causes of discontinuation and outcome after cessation of IFX.

Methods: We reviewed the charts of 850 patients with BS who were registered in our clinic between 2009 and 2013 and identified those who had used IFX. The charts of these patients were surveyed for demographic features, the reasons for IFX use, previous and concomitant drugs, IFX duration, reasons for discontinuation and time to flare after discontinuation of IFX. We defined flare as disease activity in the organ involvement that necessitated IFX use. New major organ involvement that developed during or after discontinuation of IFX were also noted.

Results: A total of 50/850 patients were treated with IFX (40 men, mean age 40±9.5 years), for uveitis (n=29), vascular involvement (n=11), parenchymal neurologic involvement (n=8), arthritis (n=1) and venous ulcer (n=1). Of these 50 patients, 22 (43%) are still receiving IFX for a median duration of 40 (IQR: 25-83) months. The remaining 28 (47%) patients had discontinued IFX after a median follow-up of 12 (IQR: 7-30) months. Reasons for discontinuation were remission in 7 patients, adverse events in 10, primary lack of efficacy in 2, and lack of patient compliance in 9 patients. Among the 7 patients who discontinued IFX due to remission, only 1 patient with uveitis had a flare, 11 months after discontinuation, while on azathioprine. The remaining 6 did not experience any flares during a median follow-up of 29.5 (IQR: 4-24) months. Five of these patients used azathioprine and 1 used mycophenolate mofetil for maintenance. Among the 10 patients who discontinued due to adverse events, IFX was switched to adalimumab in 3 patients and none experienced flares under adalimumab. The remaining 7 patients continued to receive azathioprine or mycophenolate mofetil without a biologic. Among these, 1 patient with uveitis 1 with arthritis experienced flares 6 months after discontinuing IFX. Among the 9 patients who discontinued IFX due to lack of patient compliance, 3 patients (2 with uveitis and 1 with arthritis) had flares after 5 months, 1 year and 1.5 years. IFX was re-initiated in all. The remaining 6 patients did not experience any flares after a mean follow up of 5±1.5 years. Two with uveitis and 2 with venous thrombosis used azathioprine for maintenance, while 2 patients did not receive further treatment. New major organ involvement was not observed. New BS manifestations developed in 2 patients under IFX, arthritis in one patient and both epididymitis and erythema nodosum in the other.

Conclusion: Almost half of our patients with BS remained on IFX during a median follow-up of 5.4 years (IQR:2.4-7). Main reasons for discontinuation were adverse events, remission and lack of patient compliance. Our observations further support the efficiency of IFX in managing patients with BS.

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SAT0259

ANCA-ASSOCIATED VASCULITIS WITH RENAL INVOLVEMENT: THE ROLE OF A COMBINED HISTOPATHOLOGICAL ASSESSMENT AS PREDICTOR OF PATIENTS' PROGNOSIS

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Background: Anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis often affect the kidney and renal involvement has a considerable clinical impact on patient's prognosis. Currently used histopathological classifications are basically focused on the glomerular damage and assessing chronic damage progression, but their prognostic role presented some limitations.

Objectives: To combine the Berden Classification, the ANCA Renal Risk Score (ARRS) and the Mayo Clinic-Renal Chronicity Score (RCS) with the inflammatory interstitial infiltrate and to evaluate the prognostic value of the combined assessment in patients with AAV

Methods: We included 19 AAV patients with renal involvement (mean age 63±13.2 years; disease duration 4.9±5.2 months) who underwent renal biopsy. Patients were classified according to age, sex, disease duration, ANCA

positivity. The histopathological evaluation was performed assessing the Berden category, Risk group (low, medium, high) according to the ARRS and Chronicity class according to the RCS; we also assessed the % of inflammatory interstitial infiltrate. Each patient was followed-up for 12 months; we considered the stage IV (eGFR < 30 ml/min/m²) of the KDIGO CKD Classification as renal outcome.

Results: 8 (42.1%) AAV patients were p-ANCA and 11 (57.9%) c-ANCA. 12 months after renal biopsy, 8 patients (42.1%) had a GFR <30 ml/min. According to the ARRS, 10 (52.6%) patients were in low, 7 (36.8%) in medium and 2 (10.5%) in high risk group. According to the RCS, 2 (10.5%) biopsies had minimal, 10 (52.6%) mild and 7 (36.8%) moderate chronic changes, no one presented severe chronic changes. According to the Berden classification, 6 (31.6%) samples represented the focal, 2 (10.5%) the crescentic and 11 (57.9%) the mixed category, no one represented the sclerotic class. The mean % of inflammatory infiltrate was 37.4±25.2. The interstitial inflammatory infiltrate showed a direct correlation with the severity of the Berden category (R=0.51; p=0.025), the % of sclerotic glomeruli (R=0.6; p=0.007) and the number of fibrocellular crescents (0.46; p=0.05) and an inverse correlation with the GFR at 12 months (R=-0.48; p=0.045). A ROC curve study identified a 22.5% cut-off of inflammatory infiltrate to predict the outcome of GFR at 12 months < 30 ml/min (sensitivity 88%, specificity 97.5%). Patients in focal class developed less frequently a GFR<30 (χ²=9.1; p=0.003), but there were no differences in the outcomes between the crescentic and mixed class. ARRS could differentiate risk group with regard to the renal outcome stage IV (χ²=9.0 e p=0.01) as well as the chronicity Score (χ²=8.1; p=0.017). Finally, we built a matrix combining the different histopathological scores and the % of inflammatory infiltrate to predict the outcome; we found that an inflammatory infiltrate wider than 22.5% characterizes most of patients developing stage IV chronic renal failure at the 12th month. In fact, more than 75% of patients with eGFR < 30 ml/min had inflammatory infiltrate wider than 22.5% at biopsy, despite they were in the low risk class (ARRS) and in minimal changes class (RCS).

Conclusion: Our results underline the importance of the inflammatory infiltrate in renal outcome and histology. Despite the limited number of patients, our data suggest that a combined histological score assessing the chronicity and activity of renal disease from both glomerular and interstitial perspective could better predict patients' global and renal prognosis.

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PENTOXIFYLLINE GEL FOR ORAL ULCERS IN PATIENTS WITH BEHÇET'S SYNDROME

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Background: Oral ulcers, the hallmark lesion of Behçet's syndrome (BS) can be disabling and impair eating, drinking and speaking. Despite recent advances in systemic medications for the treatment of oral ulcers, some patients do not achieve complete remission. Topical agents may help such patients by decreasing the pain and duration of oral ulcers. Pentoxifylline (PTX) is a methylxanthine derivative that inhibits phosphodiesterase and is thought to have immunomodulatory effects in addition to improving blood flow which is its main reason for use in peripheral vascular disorders.

Objectives: The aim of this study is to assess the efficacy and safety of PTX gel for oral ulcers in patients with BS. We also aimed to explore the best tools for the assessment of treatment response to topical agents in randomized controlled trials (Clinicaltrial.gov ID: NCT 03888846).