activity. While no obvious correlation was seen in Th1, Th2, Th17 and NK cells. Then the results showed there was a statistically significant decrease in the secretion of IL-10 in the BD patients ($P = 0.004$), not for IFN- γ , IL-4, IL-17 and IL-6.

To evaluate the effects of IL-2 on lymphocytes in vivo, we examined 39 inpatients who received daily low-dose IL-2 at the dosage of 50 WIU for 5 days. It showed that, besides NK cells, total T cells, B cells, CD4+ T cells, CD8+ T cells, Th1 cells, Th2 cells, and Th17 cells were all increased after IL-2 treatment. But only Treg cells were amplified more dramatically, with the four-fold increase. Accordingly, the ratio of Th17/Treg was decreased significantly in patients with IL-2 treatment, tended to balance and had no difference with healthy individuals. At the same time, we found that the symptom were mitigated obviously and disease activity including ESR and CRP were both decreased distinctly without observed side effects.

Conclusion: Absolute decrease of PB Tregs in patients with BD was associated with disease activity, which might be the major reason for imbalance of Th17/Tregs. It is speculated that BD is an autoimmune disease triggered by the defect of immunotolerance. More importantly, low-dose IL-2 proposes a selective biological treatment strategy by restoring immune tolerance and promoting rapidly remission.

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Figure 1. The ratios of Th17/Treg among Healthy controls(HC), Before treatment and After treatment.

Figure 2. The changes of disease activity in BD patients after low-dose IL-2 treatment.

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SAT0264

LONG TERM FOLLOW-UP AND OPTIMIZATION OF INFlixIMAB IN REFRACTORY UVEITIS DUE TO BEHÇET'S DISEASE. MULTICENTER STUDY OF 103 CAUCASIAN PATIENTS

J. L. Martín-Varillas¹, B. Atienza-Mateo², V. Calvo-Río², E. Beltrán³, A. Adán⁴, E. Aurrecoechea¹, S. Castañeda⁵, M. A. González-Gay², J. L. Hernández², R. Blanco² on behalf of Infliximab in Behçet-uveitis Group. ¹H. Sierrallana, Torrelavega, Spain; ²H.U. Marqués de Valdecilla, Santander, Spain; ³H. Del Mar, Barcelona, Spain; ⁴H. Clinic, Barcelona, Spain; ⁵H.U. La Princesa, Madrid, Spain

Background: Biologic therapy has improved prognosis of Behçet Disease (BD) uveitis (1-5). Although infliximab (IFX) is approved in Japan, most data in Caucasian patients comes from small series. No data on optimization has been published

Objectives: In a large series of Caucasian patients with refractory uveitis of BD, we assess: **a)** long-term efficacy and safety; **b)** IFX optimization when ocular remission was achieved

Methods: Multicenter study of IFX-treated patients with BD uveitis refractory to conventional immunosuppressants. 103 patients were treated with IFX as 1st biologic as follows: 3-5 mg/kg i.v. at 0, 2, 6 and every 4-8 weeks. The main outcomes were anterior chamber cells, vitritis, retinal vasculitis, macular thickness, visual acuity, and glucocorticoids sparing effect; analysed at baseline, 1st week, 1st and 6th months and 1st and 2nd years. After remission, IFX optimization was performed

Results: In whole series (n=103), main outcomes showed a rapid and maintained improvement, reaching remission in 78 patients after a mean IFX duration of 31.5 months. Severe side-effects were observed in 9 patients.

Comparative study between optimized and non-optimized groups showed: **a)** no differences in clinical baseline characteristics; **b)** similar maintained improvement in most ocular outcomes; **c)** lower severe adverse events and **d)** lower IFX cost in optimized group (4826.52 vs 9854.13 euros/patient/year) (**Table**)

Conclusion: IFX seems effective and safe in Caucasian patients with refractory BD uveitis. IFX optimization is effective, safe, and cost-effective

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Table.

	Optimized N=18	Non Optimized N=42	P
Patients/eyes affected, n/n	18/34	42/77	
Age, mean (SD), years	39.5 (9.8)	38.8 (10.5)	0.82
Men, %	55.6	59.5	0.78
Duration of uveitis before IFX, median [IQR] months	38 [18-119]	35 [10-48]	0.11
Ocular features at time of IFX onset			
-AC cells count, median [IQR]	2 [1-4]	2 [1-2]	0.29
-Vitritis, median [IQR]	2 [1.5-3]	2 [1-2]	0.02
-BCVA, mean (SD)	0.32 (0.21)	0.37 (0.26)	0.51
-OCT, mean (SD)	303.5 (23.3)	397.7 (155.7)	0.12
-Retinal vasculitis, n (%)	9 (50)	26 (66.7)	0.23
Uveitis pattern, n (%)			
-Bilateral/unilateral	16/2 (88.9/11.1)	35/7 (83.3/16.7)	0.71
-Anterior	0 (0)	6 (14.3)	0.17
-Posterior	5 (27.8)	8 (19.0)	0.50
-Panuveitis	13 (72.2)	28 (66.7)	0.67
Prednisone dose at IFX onset, mean (SD), mg/d	40.3 (20.6)	41.4 (15.5)	0.81
IFX therapy			
-Monotherapy/combined treatment, n (%)	15 (83.3)	30 (71.4)	0.33
-AZA	5 (27.8)	4 (9.5)	0.11
-CsA	9 (33.3)	8 (19.0)	0.32
-MTX	4 (22.2)	15 (35.7)	0.30
Follow-up on IFX therapy, median [IQR], months	48 [33-60]	24 [6-60]	0.007
-Relapses, median (IQR)	0 [0-1]	0 [0-2]	
-Remission, %	100	75.6	0.46
-Severe side effects, n (per 100 patients/year)	0 (0)	3 (0.78)	0.02
-Cost (mean), euros per year	4826.52	9854.13	0.55

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SAT0265

RISK FACTORS FOR INFECTIOUS COMPLICATIONS FOLLOWING RITUXIMAB TREATMENT – MULTICENTER POLISH EXPERIENCE

A. Masiak¹, M. Ziętkiewicz¹, K. Wójcik², K. Wawrzycka-Adamczyk³, M. Madej³, J. Kur-Zalewska⁴, M. Wisłowska⁵, H. Storonik⁶, M. Komorniczak⁶, I. Brzozko⁷, M. Brzozko⁷, A. Dębska-Słizien⁶, J. Musiał², Z. Zdrojewski¹. ¹Medical University of Gdańsk, Department of Internal Medicine, Connective Tissue Diseases and Geriatrics, Gdańsk, Poland; ²Jagiellonian University Medical College, 2nd Department of Internal Medicine, Faculty of Medicine, Krakow, Poland; ³Medical University, Department of Rheumatology and Internal Medicine, Wrocław, Poland; ⁴Military Medicine Institute, Department of Internal Medicine and Rheumatology, Warsaw, Poland; ⁵Department of Internal Diseases and Rheumatology, Central Clinical Hospital of the Ministry of the Interior and Administration, Department of Internal Diseases and Rheumatology, Warsaw, Poland; ⁶Medical University of Gdańsk, Department of Nephrology, Transplantology and Internal Diseases, Gdańsk, Poland; ⁷Pomeranian Medical University in Szczecin, Department of Internal Medicine, Rheumatology, Geriatrics and Clinical Immunology, Szczecin, Poland

Background: Rituximab (RTX) is a B cell depleting monoclonal antibody with proven efficacy in the treatment of ANCA-associated vasculitis (AAV). The infectious complications occur in 15-25%.

Objectives: We aimed to assess the frequency and risk factors of infections in patients with AAV receiving RTX among Polish patients.

Methods: 7 tertiary referral centers experienced in the treatment of vasculitis completed a questionnaire regarding AAV patients treated with RTX.

Results: Among 49 patients included in the analysis (47 with GPA, 2 with MPA; 36/73% men; mean age at diagnosis 42.45±14.9 yrs., mean age on RTX initiation 46.14±14.72 yrs.) at least one infection occurred in 20 patients (40.82%) after mean time of 16.65±16.01 weeks since the administration of RTX. Patients were followed for a mean time of 26.88±21.94 months. There were no differences in the incidence of infectious complications by gender, age, BMI, smoking status, severity of the disease, activity of the disease (BVAS), time from diagnosis to RTX initiation, carriage of staphylococcus aureus in the upper respiratory tract, total dose of CYC before RTX treatment. We didn't observe severe hypogammaglobulinemia or neutropenia after RTX treatment. 40% of the observed infections occurred during the first month, 35% between second and sixth month of follow-up, while 25% were observed between 6 and 12 months after the RTX initiation. Of the 20 patients who developed infection, 12 (24.5%) had further infections. Antibiotic prophylaxis with trimethoprim-sulfamethoxazole was administered in 40 out of 49 (81.63%). Upper respiratory tract infection was the most common infectious complication (n=11), followed by lower respiratory tract (n=4), soft tissues (n=4) and urinary tract infections (n=4), lacrimal gland abscess (n=2) and abdomen (n=1). In cases with a positive microbial result Staphylococcus aureus (n=4), Klebsiella pneumoniae (n=2), Pseudomonas aeruginosa (n=1), Candida (n=1) and others (n=6) were identified. No fatalities were recorded and only 3 patients had severe infection with the necessity of prolonged treatment.

Conclusion: Despite the high number of infections in our group treated with RTX, most of them were not severe. Upper respiratory tract was the most common site of infection.

Disclosure of Interests: None declared

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SAT0266

FAMILIAR AGGREGATION OF LONGEVITY IN GIANT CELL ARTERITIS AND POLYMYALGIA RHEUMATICA

M. Milchert¹, M. Brzozko¹. ¹Pomeranian Medical University, Rheumatology, Internal Medicine, Geriatrics and Clinical Immunology, Szczecin, Poland

Background: The long-term mortality in giant cell arteritis (GCA) and polymyalgia rheumatica (PMR) is unexpectedly decreased (1,2,3,4) or at least not increased regardless increased mortality risk factors that these diseases share with other systemic inflammatory disorders.

Objectives: We aimed to test the hypothesis on aggregation of increased longevity in families of PMR/GCA patients because the family members of long-lived subjects have a survival advantage.

Methods: After questioning our patients we compared age of death of 358 parents of 179 PMR and GCA patients with corresponding data retrieved from 506 parents of 235 randomly collected age and sex matched controls.

Results: We found the number of nonagenarian (≥90 year old) mothers of PMR/GCA patients significantly higher vs controls. Both nonagenarian parents were found in 6 patients (3.35%) and in none of the controls. Decreased number of nonagenarian fathers of our patients remains unexplained.

Conclusion: Confirming our findings in a wider studies would imply a need of including some genetic or behavioural factors to explain PMR/GCA survival advantage.

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Table 1. Number of nonagenarians (≥90 years olds) in parents of PMR/GCA patients

	Parents age	PMR/GCA (N=179)	Controls (N=253)	OR	95%CI	p
Mothers	<90	148 (82.68%)	243 (96.05%)			
	≥90	31 (17.32%)	10 (3.95%)	2.34	1.11-11.95	<0.0005
Fathers	<90	161 (89.94%)	203 (80.24%)	0.45	0.24-0.83	0.0064
	≥90	18 (10.06%)	50 (19.76%)			
One of parents	<90	136 (75.98%)	193 (76.28%)	1.02	0.63-1.63	0.9412
	≥90	43 (24.02%)	60 (23.72%)			
Both parents	<90	173 (96.65%)	253 (100.00%)	8.77	2.26-405.10	0.003
	≥90	6 (3.35%)	0 (0%)			
Mothers of female patients	<90	105 (84%)	149 (97%)	7.1	2.27-29.19	0.0001
	≥90	20 (16%)	4 (3%)			
Mothers of male patients	<90	43 (80)	94 (94%)	4.01	1.25-13.97	0.0066
	≥90	11 (20%)	6 (6%)			

N - number of all parents

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SAT0267

ROLE OF AGGRESSIVE IMMUNOSUPPRESSION ON SUBGLOTTIC STENOSIS IN GRANULOMATOSIS WITH POLYANGIITIS: RETROSPECTIVE ANALYSIS OF A MONOCENTRIC COHORT

L. Moroni^{1,2}, L. Giudice², G. A. Ramirez^{1,2}, S. Sartorelli¹, A. Cariddi¹, A. Carretta^{2,3}, E. Bozzolo¹, L. Dagna^{1,2}. ¹IRCCS San Raffaele Hospital, Unit of Immunology, Rheumatology, Allergy and Rare Diseases, Milano, Italy; ²Vita-Salute San Raffaele University, Milano, Italy; ³IRCCS San Raffaele Hospital, Unit of Thoracic Surgery, Milano, Italy

Background: Subglottic stenosis (SGS) is defined as airway narrowing below the vocal cords and is a common and potentially life-threatening manifestation of Granulomatosis with Polyangiitis (GPA), with an estimated prevalence of 16-23% (1). Balloon catheter dilation is effective in GPA-related SGS, but relapses are frequent. Little is known about the role of immunosuppression in this setting.

Objectives: to analyse the clinical characteristics of a monocentric GPA cohort, describe phenotype differences among patients with and without SGS and investigate the role of surgical and medical treatments on relapse risk and general outcome.

Methods: Biopsy-proven patients with SGS were identified by review of medical charts among a cohort of patients with GPA, classified according to the algorithm of the European Medicine Agency (2). The clinical characteristics