Also, we observed that level of HDLP-C is higher in patients with early stages than in late stages of AN (1.55 (1.31-1.57) vs. 1.23 (1.04-1.36) mmol/l, $p=0.04$). Thus, HDLP-C can be interpreted as a protective factor against contralateral joint involvement in AN patients. The data obtained is consistent with the existing data that HDLP-C lowers the risk for cardiovascular events.

Figure 2. HDLP-C levels in patients with early and late stages of avascular necrosis

Conclusion: The data obtained indicate a significant role of dyslipidemia in the pathogenesis of AN in the context of vascular theory.

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SAT0522

PROGRESSION OF VISION-RELATED QUALITY OF LIFE AND IDENTIFICATION OF RISK FACTORS IN NON-INFECTIOUS UVEITIS PATIENTS

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Background: Uveitis are characterized by inflammation of the middle layer of the eye wall. In developed countries uveitis are the second major treatable cause of blindness in those 20–65 years of age. Additionally, more than 50% of the subjects affected with these conditions will develop complications related to the uveitis, and more than 30% will suffer visual impairment. As a result, these conditions are associated with an important burden. The assessment of the patient's quality of life (QoL) through standardized and validated questionnaires allows us to evaluate objectively the burden of the disease. Several studies have shown that the QoL of uveitis patients is reduced when compared with that of general population. Moreover, several socio-demographic and clinical related characteristics have been associated with impaired QoL. However, no longitudinal analysis of the vision-related (VR) QoL in clinical practice has been carried out.

Objectives: To describe VR-QoL in non-infectious uveitis (NIU) patients during a follow-up period of two years. Furthermore, to analyse the influence of socio-demographic, clinical and treatment factors on the progression of VR-QoL.

Methods: Longitudinal prospective study which includes patients examined in a multidisciplinary tertiary uveitis clinic, with a diagnosis of NIU. In each of these patients a yearly determination of VR-QoL was carried out following the VFQ-25 questionnaire, finally including all those who had completed at least an initial questionnaire and a second one after two years of follow-up. Analysis of risk factors at baseline in repeated VFQ-25 measurements was carried out by generalized estimating equations (GEE) models. Variables related to demographic, clinical and treatment factors with a determination of p -value <0.15 were included in

multivariable models, which were then compared using the *Quasi Akaike Information Criteria* (qAIC). A local Ethics Committee approved the execution of this project.

Results: 128 patients were included, 117 of which also had an evaluation after the first year of follow-up. 55.5% were female with a median age of 34 years at the start of symptoms and of 37 years at the moment of attending our clinic for the first time. First evaluation of VR-QoL was determined a median (p25-p75) of 6.1 (1.8-13.1) years after that first visit. The most frequent locations of NIU were anterior (41.1%), panuveitis (27.4%), posterior (16.1%) and intermediate (15.3%). At our first evaluation, 27.3% of patients were receiving treatment with topical steroids, 22.3% oral, 49.2% immunosuppressant drugs (both synthetic and/or biological) and 19.05% biological therapies. The median (p25-p75) VFQ25 determinations at baseline, first and second years of follow-up were 0.87 (0.78-0.93), 0.88 (0.80-0.93) y 0.89 (0.81-0.94), with no significant differences (first year vs. Baseline $p = 0.54$; 2 years vs. Baseline $p = 0.61$).

In the GEE multivariable models the presence at baseline of permanent incapacity due to NIU, concomitant thyroid disease, worse visual acuity, unilateral pattern, cataracts, retinal vasculitis, epiretinal membrane and use of azathioprine were independently associated with a worse VR-QoL (Table 1).

Table 1. Risk factors related to VR-QoL in patients with NIU

Variables	Coef. (IC 95%)	p-value
Visual acuity	23.6 (12.3 - 34.8)	<0.01
Permanent incapacity	-24.8 (-33.7 - -15.9)	<0.01
Unilateral NIU	-2.9 (-5.7 - -0.006)	0.05
Cataracts	-5.2 (-10 - -0.3)	0.037
Vasculitis	-13.3 (-23.4 - -3.1)	0.011
Epiretinal membrane	-6.8 (-12.7 - -0.8)	0.026
Azathioprine	-7.5 (-14.7 - -0.3)	0.041

Conclusion: During these two years of follow-up, no significant changes have taken place regarding VR-QoL in patients with NIU assessed at a tertiary centre. Other than visual acuity at baseline, certain ocular manifestations and clinical comorbidities have also been shown to have an independent effect on the VR-QoL of these patients.

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SAT0523

BIOLOGICAL THERAPY IN REFRACTORY ATYPICAL OPTIC NEURITIS. MULTICENTER STUDY

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Background: Optic Neuritis (ON) is an inflammation of the optic nerve. Its most common presentation is demyelinating typical ON. Atypical ON is rare, severe, non-demyelinating and can be isolated or associated to different diseases including autoimmune diseases. If it is not treated, it can lead to devastating visual results. Conventional treatment includes systemic corticosteroids and conventional immunosuppressants (CIS).

Objectives: Our aim was to assess the efficacy of biological therapy in atypical ON refractory to conventional treatment.

Methods: Open-label multicenter study including 19 patients diagnosed with atypical ON refractory to systemic corticosteroids and at least one CIS. The main outcomes assessed were Best Corrected Visual Acuity (BCVA) and optic nerve and ganglionar cells Optical Coherence Tomography (OCT). These outcome variables were recorded at baseline, 1 week, 2 weeks, 1 month, 3 months and 6 months and 1 year after biological therapy onset.

FIGURE

Results: We studied 19 patients (12 women/7 men); mean age of 34.8 ± 13.9 years. The underlying diseases were idiopathic ($n=7$), Behçet's disease ($n=5$), systemic lupus erythematosus ($n=2$), neuromyelitis optica ($n=3$), sarcoidosis ($n=1$) and relapsing polychondritis ($n=1$) (TABLE). Before biological therapy and besides systemic corticosteroids, patients had received different CIS. Biological therapy was adalimumab ($n=6$), rituximab ($n=6$), infliximab ($n=5$) and tocilizumab ($n=4$). After biological therapy, an improvement in ocular parameters was observed: BCVA [0.7 ± 0.3 to 0.8 ± 0.3 ; $p=0.03$], optic nerve OCT [123.2 ± 58.3 to 190.5 ± 175.4 ; $p=0.11$], and ganglionic cells OCT [369.6 ± 137.4 to 270.7 ± 23.2 ; $p=0.03$] at one year (FIGURE). After a mean follow-up of 29.1 ± 19.2 months, there were no severe adverse effects observed.

Conclusion: Biological therapy may be effective in patients with refractory atypical ON.

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TABLE

Case	Gender/ Age	Underlying disease	Laterality	IV steroids dose (g)	Maximum prednisone oral dose (g)	Conventional immunosuppressants	Biological therapy	Adverse effects
1	F/29	Idiopathic	Unilateral	4	60	AZA	TCZ	No
2	F/26	Idiopathic	Bilateral	5.5	30	AZA	TCZ	No
3	F/13	Idiopathic	Bilateral	-	10	MTX	ADA	No
4	F/25	Idiopathic	Bilateral	4	60	MTX	IFX, TCZ	No
5	F/24	Idiopathic	Bilateral	0.5	60	MTX, AZA	ADA	No
6	M/14	Idiopathic	Bilateral	-	10	MTX	ADA	No
7	F/30	Vasculitis ANCA+	Unilateral	3	60	AZA, MMF, LFM, CFM	RTX	Yes
8	M/21	Behçet	Bilateral	-	60	MTX, AZA	ADA	Nausea Vomits
9	M/25	Behçet	Unilateral	0.5	60	MTX, CyA	ADA	No
10	M/39	Behçet	Unilateral	3	80	MTX, MMF	IFX	No
11	M/40	Behçet	Unilateral	-	80	MMF	IFX	No
12	M/37	Behçet	Unilateral	-	60	CyA	IFX	No
13	F/68	NMO	Unilateral	2.5	30	CFM, AZA	RTX	No
14	F/41	NMO	Unilateral	3	60	CFM	RTX	Infection
15	F/43	NMO	Bilateral	5	60	AZA	RTX	Infusion reaction
16	F/56	SLE	Unilateral	-	60	HCQ, MMF, CFM	RTX	No
17	F/47	SLE	Unilateral	5	60	HCQ, MMF	RTX	No
18	F/43	Relapsing polychondritis	Bilateral	3	60	MTX, CFM	IFX, TCZ	No
19	M/41	Sarcoidosis	Bilateral	3	40	AZA	ADA	No

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SAT0524

THE INCIDENCE RATE OF ADULT ONSET STILL'S DISEASE IN SLOVENIA

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Background: Adult Onset Still's disease (AOSD) is an uncommon systemic inflammatory disease.

Objectives: To determine for the first time the incidence rate of AOSD in our population.

Methods: We retrospectively collected AOSD cases diagnosed between 1 January 2010 and 31 December 2019 at our secondary/tertiary rheumatology centre, which is the only referral centre for an average population of 704,000 adults. AOSD cases were identified by searching the electronic medical database both for ICD-10 code M06.1 and a full text search for »AOSD«. Patients' records were analyzed and descriptive statistics was used to describe our study group. The adult population was obtained from the national statistics institute database. The annual incidence rate for AOSD was calculated.

Results: During the 10-year observation period we identified 22 incipient AOSD cases. All 22 cases fulfilled Yamaguchi classification criteria for AOSD¹. Five cases were excluded from analyses since they were referred to our department from regions served by other secondary/tertiary centres. Hence, we finally analyzed 17 AOSD cases (11 females; median (IQR) age 38.9 (29.9; 56.5) years, range 20-71 years), resulting in the average annual incidence rate of 2.4 (95%CI 1.5-3.8) cases per 10⁶ adults. Age specific incidence rate of AOSD is presented in Figure 1. Clinical characteristics of AOSD cases at presentation are shown in Table 1. AOSD was complicated with macrophage activating syndrome in 4/17 (23.5%) cases, and with pulmonary hypertension in one case. Patients were followed for a median (IQR) 31 (20; 58) months. Twelve (70.5%), 2 (11.8%), and 3 (17.6) patients had monophasic, relapsing, and chronic disease course, respectively.

Table 1. Clinical characteristics of AOSD at presentation

Characteristic	AOSD (%)	Characteristic	AOSD (%)
Female gender	64.7	Lung infiltrates	23.5
Age*	38.9 (29.9;56.5)	Pericardial effusion	23.5
Fever	94.1	Abdominal pain	17.6
Weight loss	64.7	Lymphadenopathy	52.9
Skin rash	76.5	Splenomegaly	41.2
Throat pain	88.2	Hepatomegaly	17.6
Arthralgia/Arthritis	88.2/47.1	Leukocytosis	88.2
Myalgia	29.4	Elevated AST/ALT	88.2
Pleural effusion	23.5	Ferritin >1000ng/ml	94.1

Legend: *median (IQR);