insufficient data to establish safety in countries with high background prevalence of TB. Long term prospective national registries are needed from in TB countries with focus on risk factors for infections.

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AB0990

SECONDARY SUBACUTE ARTHRITIS IN CHILDREN WITH DIASTROPHIC DYSPLASIA AND RMED

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Background: Progressive osteoarthritis is common in skeletal dysplasias. In the most of these disorders progress is relatively slow and acute pain with severe disability secondary to osteoarthritis is rare during childhood. Diastrophic dysplasia and rMED are quite unique among other skeletal dysplasias for secondary subacute arthritis (SSA). Protracted course of SSA can mimic JIA.

Objectives: To analyse incidence and features of SSA in group of patients with DD/rMED.

Methods: We retrospectively analysed for SSA our series of 39 patients with DD/rMED. Clinical, radiological and laboratory data were collected. Clinical assessment included pain (VAS), ROM (range of motion) and postural/walking disturbances. Radiological type by Yasunaga classification, neck-shaft angle (NSA) and articulo-trochanteric distance (AT distance) were estimated. MRI data regarding cartilage damage, joint effusion and bone marrow condition were noticed. Biomarkers of inflammation and immune response (ANA, RF, vimentin antibodies) were assessed in blood samples.

Results: We identified 17 patients with hip joint SSA among 39 patients with DD/rMED (43%). Bilateral involvement was identified in 13 children with asynchronous appearance in all cases (from 2 to 18 months before the symptoms on the other side). Trauma (including iatrogenic damage during physiotherapy) preceded SSA in 9 cases. Pain, limited range of motion, limping and antalgic posture throughout the day were noticed in all the cases. Duration of these symptoms was from 4 weeks to 9 months. Progressive phase (increasing symptoms) took from 2 weeks to 4 months. General laboratory data were normal or indicated moderate inflammatory response without any specific changes. Radiological data shows predictive signs like NSA<110°, AT distance <10mm, fair or poor congruency by Yasunaga classification. Also radiological data demonstrated progressive subluxation with narrowing of articular space, osteoporosis, subchondral cysts.

MRI revealed pseudo-erosive damaged cartilage in contact area with joint effusion and bone marrow oedema. Total cartilage matrix also visualized like intermittent and multi-layered = erosive-like chondrolysis (defective articular hyaline cartilage) in 11 patients (65%).

Management included bed rest or partial weight bearing. NSAID were prescribed for 2-4 weeks with following usage according to the symptoms. Physical therapy to maintain range of motion was provided. One patient was operated (containment surgery for subluxation). In follow-up (2-7 years) 12 patients were painless at the daily life. 4 patients had intermittent pain and one patient (operated) - daily moderate pain. Range of motion was restored in 11 patients. Those patients who underwent in-hospital rehabilitation immediately after appearing of the symptoms demonstrated better outcome.

Conclusion: SSA is typical for DD/rMED and leads to remarkable disability. Early recognition and non-surgical management are important for recovery. The quick reversibility of the clinical picture arthritis against the background of a short course of NSAIDs and rehabilitation is a characterized of non-autoimmune secondary inflammatory process (SSA). SSA not requires anti-rheumatic treatment in children with DD/rMED.

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AB0991

EPIDEMIOLOGY AND CLINICAL FEATURES OF CHRONIC JOINT PAIN IN CHILDREN AND ADOLESCENTS

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Background: Arthralgia in children for many years continues to maintain the status of the most common symptom of rheumatic diseases. However this symptom should not always be interpreted as a manifestation of arthritis. Well known that arthralgia in growing children is a frequent problem which can be caused by pathological or innocuous process.

Objectives: The goal of this study was to analyze the structure of childhood arthralgia.

Methods: We carried out a retrospective review of 600 children who applied to the outpatient department of the institute with a complaint of pain lasting longer than two months in one or more joints. The clinical, instrumental and laboratory pictures were studied. Special attention was paid to certain aspect of joint pain by the child or his parents. The data obtained made it possible to systematize and detail the nature of the articular pathology in children of various age groups.

Results: All children were divided into several groups based on their anatomical and physiological characteristics of osteoarticular system: the first group consisted of 240 children under 6-7 years old, the second group – 220 children 7-12 years old, the third group – 140 children over 12 years old.

Research suggests that more preschool children were experience bilateral lower extremity pain by "post-walk genesis" due to natural hypermobility, immaturity of sensory innervation of the joints and imbalance of the leg muscles (e.g. growing pains). The second most common cause was joints pain associated with infectious factor (post-infectious genesis or chronic foci of infection). The frequency of juvenile arthritis and other rheumatic diseases in children of this age group did not exceed 10%. Special attention was paid to nightpain with fever and changes in blood tests to exclude malignancies manifestation and other tumors (less 5%).

The most common causes of joint pain of school-age children were hypermobility syndrome and enthesopathy (primary, secondary). Secondary enthesopathy were result of changes in nutrition, rapid growth and excessive exercise. Also enthesopathy were manifestation of endocrine, gastrointestinal or infectious diseases. The proportion of children with the onset of chronic inflammatory arthropathy also did not exceed 10%. Hypermobility child's syndrome was characterized by harmless pain, linked to physical activity (less morning stiffness).

Over the past decade, we've seen a gradual increase in the number of children with diagnosed patellofemoral pain (non-traumatic) and mediopatellar plica syndromes (95% were girls). In most cases children was complicated by syndrome of increased anxiety. Cases of apophysitis as cause of chronic arthralgia were over 15%. The share of true chronic inflammatory arthropathies, including spondylitis, in children of this age group did not exceed 10%. Fibromyalgia were diagnosed less 5%.

Conclusion: Despite continuous improvements in examination technique and image quality there is no universal test to diagnose cause of childhood arthralgia. Age features, individual nature of pain perception, the high frequency of incomplete and transient forms of arthropathy, cases atypical joint diseases have been intriguing problems for diagnostic pathology. Integrated assessment modelling framework of the clinical and instrumental pictures with understanding of the anatomical and physiological characteristics of childhood will help identify the true cause of chronic musculoskeletal pain. there is no single test to diagnose CA

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AB0992

CONNECTING SLEEP QUALITY, PAIN AND MOOD DISTURBANCES IN JUVENILE FIBROMYALGIA

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Background: Subjective sleep problems, including difficulties falling asleep, waking up, un-restorative sleep and daytime sleepiness are highly prevalent in patients with juvenile fibromyalgia (JFM). Sleep disturbances has been considered a consequence of severe pain and depression, but also in healthy individuals sleep deprivation is also a risk factor for the development of chronic widespread pain, tenderness and fatigue, suggesting the important role of sleep in pain control and in the pathophysiology of fibromyalgia.

Objectives: To estimate the incidence of polysomnographic alterations in JFM and to explore the relationship between sleep problems and the musculoskeletal pain, fatigue and mood and anxiety disorders.

Methods: 21 patients (M 3; F 18; mean age 16,1) with JFM were included. The objective sleep quality was measured by overnight polysomnography (PSG) (using the EMBLETTA MPR PG device). PSG data were compared to age and sex-matched controls. The subjective sleep disturbances were assessed by the Sleep Condition Indicator (SCI). Musculoskeletal symptoms were evaluated by using the widespread pain index (WPI). Pain intensity was evaluated on a 0-10 visual analogical scale (PVAS). Fatigue was assessed by using the Symptom Severity (SS) questionnaire. Mood and anxiety disorders were evaluated by using the Children Depression Index (CDI) and the Multidimensional Anxiety Scale for Children (MASC). Comparison of categorical data was performed by means of the Fisher's Exact test. The relationship between sleep quality and clinical symptoms were assessed using Spearman's rank order correlation coefficient (rs). All statistical test were 2-sided and p values less than 0.05 were considered statistically significant.

Results: Nineteen out of 21 (90.5%) patients complained subjective sleep disturbances and un-restorative sleep. Seven out of 21 (33.3%) patients had mood and anxiety disorders. Eight out of 21 patients (38.1%) showed an electroencephalographic pattern of alpha wave intrusion in slow wave sleep (SWS). SCI was significantly correlated to CDI score $r_s = -0.775$ ($p \leq 0.0001$), MASC 0,61 ($p = 0.005$), WPI -0,731 ($p = 0.001$), SSI 0,492 ($p = 0.038$), PVAS -0,590 ($p = 0.006$).

Conclusion: A substantial percentage of JFM patients experience sleep disturbances, which are, correlated with the severity of the musculoskeletal symptoms and mood and anxiety disorders. One third of JFM patients have alpha intrusion in the SWS. The important role of sleep in pain control suggests that the development of treatments to improve sleep quality may lead to more effective management of fibromyalgia in the future.

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AB0993

A CASE SERIES OF KAWASAKI DISEASE FROM KENYA

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Background: Kawasaki disease (KD) has been described across the globe, including the African continent, but none yet from Kenya.

Objectives: To describe the clinical features and management strategies of pediatric patients diagnosed with Kawasaki Disease at a tertiary referral hospital in Kenya.

Methods: A retrospective chart review was undertaken for the period January 2013 to December 2017 for all pediatric patients admitted at Aga Khan University Hospital Nairobi, Kenya. All medical records with a discharge diagnosis of Kawasaki disease were reviewed, de-identified and data extracted using a data collection tool.

Results: Among the 15 cases identified, 8 (53%) had complete KD. The mean age was 1 year 10 months with a slight increase in males (53.3%). The mean duration of symptoms at diagnosis was 7.2 days (range 1-11 days). Fourteen patients (93.3%) received both intravenous immunoglobulin and aspirin but dosing varied from high dose aspirin (80-90mg/kg/day) to low dose aspirin (3mg/kg/day). Baseline cardiac evaluations were done among these 14 (93.3%) and one patient was found to have bilateral dilated coronaries. Only 5 patients (33.3%) had repeat echo examinations within 6 weeks after diagnosis all of which were normal.

Conclusion: The challenges faced in the management of KD in Kenya include awareness of the disease, access and expertise to pediatric echocardiography, follow-up, access and cost of IVIG. Increasing awareness and improving health care resources is important in improving outcomes of KD in Kenya.

Keywords: Kawasaki Disease, Pediatric Rheumatology, Kenya, Global Health, Vasculitis

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AB0994

NEW ALTERNATIVE IN THE TREATMENT OF PATIENT WITH MUTATION OF GEN LACC1

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Background: Few patients have been described in the literature with mutations in the Lacasa Domain containing one (LACC1) gene. Its clinical presentation usually associates sustained systemic inflammation associated with chronic polyarticular erosive arthritis. Until now, there have been multiple treatments described to try to control the disease, however, they are generally unsuccessful in the long term.

Objectives: Describe the clinical course of a patient as well as the different treatments used

Methods: Clinical chart review

Results: Female 18-year-old born from a consanguineous Moroccan couple. Mother, brother and sister with similar conditions. She started at 3 years with fever, anemia, intense elevation of acute phase reactants and symmetric polyarthritis (knees, elbows, carps, shoulders, hands and ankles). Subsequent whole exome sequencing identified c.128_129delGT mutation in the LACC1/FAMIN gene. During the course of her illness, she has received treatment with oral, intravenous and infiltrated corticosteroid, methotrexate and etanercept, without getting adequate control of the disease. In 2016, she started treatment with tocilizumab (8 mg / kg every two weeks), obtaining an acceptable control of the disease (requiring periodic infiltrations every 2-3 months due to persistent arthritis). Nonetheless, in April 2019, she consulted for clinical worsening of the arthritis and laboratory test (C reactive protein 99.7 mg / L, erythrocyte sedimentation rate 53 mm / h, leukocytes 13,500/ μ L and neutrophils 10,930/ μ L). At that time, she discontinued therapy with tocilizumab and started tofacitinib 5mg every 12 hours with good evolution. Since its introduction, it has not required joint infiltration again and the inflammatory parameters (persistently elevated previously) have normalized.

Conclusion: The jak kinasa inhibitors may be a treatment option in those patients with bad response to conventional therapy.

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AB0995

JUVENILE ONSET SYSTEMIC LUPUS ERYTHEMATOSUS WITH SJÖGREN'S SYNDROME: CLINICAL AND LABORATORY FEATURES.

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Background: Systemic lupus erythematosus with juvenile onset (jSLE) with Sjogren's syndrome (SS) in children is a poorly studied and rare combination, the frequency of which, according to the literature, is 7.5-10.0%¹.

Objectives: To study demographic data, specific features of jSLE with SS in single center.

Methods: Retrospective study of all consequently patients (pts) of single-center in pediatric department with combination of jSLE and SS.

Results: SS was verified in 14 pts with jSLE (14.3% were boys), which amounted to 15.5% of all pts with jSLE. The median age of jSLE onset was 13.5 y.o. [9.3; 14.9]. The median of disease duration at the time of SS verification was 1.3 y [0.6; 2.9].