if the number of patients is small. Further studies are needed to identify a reliable predictive marker of uveitis risk in JIA patients. The finding of a significant greater prevalence of anti-DFS70 autoantibodies in healthy ANA + subjects allows to suppose that this autoantibody could represent a possible protective marker for development of AARDs in asymptomatic children with isolated ANA positivity, as for adults. To confirm this hypothesis, it would be useful to carry on the study prospectively, encompassing children with other rheumatological diseases, and prolonging the clinical and laboratory follow up.

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AB1004 JUVENILE DERMATOMYOSITIS (JDM) IN SOUTHEAST ASIA: A 20-YEAR SINGAPORE EXPERIENCE

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Background: Juvenile dermatomyositis (JDM) is a multisystem inflammatory disease of childhood with variable demographics, clinical features and outcomes. No studies have described the characteristics of JDM patients from Southeast Asia population.

Objectives: To describe the clinical characteristics and outcomes of JDM patients in Singapore over a 20-year period.

Methods: Patients diagnosed with JDM from 1999 to 2019 at KK Women's and Children's Hospital, Singapore, were recruited. Nonparametric descriptive statistics were used to described data. Kaplan-Meier analyses were used to estimate the probability of remission. Multivariate logistic and Cox regression analyses were used to determine predictors as appropriate. The significant level was set at < 0.05.

Results: 32 JDM were identified. Clinical characteristics and treatment used are shown in Table 1.

	All (n=32)	Monophasic (n=17)	Polyphasic (n=14)
Male	14 (43.8)	7 (41.2)	7 (50.0)
Age at onset (yrs)*	6.4 (4.5 – 9.8)	5.4 (4.1 – 8.5)	7.4 (5.6 – 12.3)
Lag period (mo)*	3.5 (1.0 – 12.5)	2.0 (1.0 – 16.8)	6.8 (1.2 – 15.8)
Helioprope	16 (50)	9 (52.9)	7 (50)
Gotttron papule	23 (71.9)	12 (70.6)	11 (78.6)
Malar rash	19 (61.3)	9 (52.9)	10 (71.4)
Vasculitic rash	19 (61.3)	8 (47.1)	11 (78.6)
Arthritis	10 (31.3)	3 (17.6)	7 (50)
Nailfold changes	28 (87.5)	15 (88.2)	13 (92.9)
Calcinosis	9 (28.1)	4 (23.5)	5 (35.7)
Positive ANA	17 (53.1)	10 (58.8)	7 (50)
Positive Myositis antibodies	4 (12.5)	2 (11.8)	2 (14.3)
Laboratory at diagnosis, U/L*			
CK	324 (134 – 2229)	746 (139 – 2965)	351 (155 – 2622)
LDH	650 (450 – 943)	650 (398 – 1015)	714 (512 – 944)
ALT	28 (16 – 106)	35 (18 – 109)	38 (15 – 104)
AST	50 (30 – 108)	50 (31 – 113)	85 (36 – 215)
Aldolase	13.7 (8.1 – 28.0)	14.2 (8.4 – 26.6)	16.3 (8.6 – 38.5)
CMAS score at diagnosis	29 (21 – 43)	28 (21 – 35)	35 (11 – 43)

*median (IQR), otherwise - n (%)

Pulse methylprednisolone (pMP) was used in 53.1% of patients after diagnosis. Median time to inactive disease (ID) was 5.3 months (IQR 2.8 – 12.8). Male, older age and patients on pMP ($p = 0.003$ - 0.044) achieved ID sooner. Older patients also developed disease flare sooner after achieving ID ($p = 0.024$). No clinical features nor lab investigations predicted JDM disease course. Malay patients was associated with higher risk of calcinosis ($p = 0.017$).

Compared to adult dermatomyositis patients in Singapore¹, our cohort had more cutaneous manifestations including malar rash, vasculitic rash and nailfold changes. Table 2 shows the time for each muscle enzymes to normalise.

CK	1.49 (0.69 – 3.53)
LDH	4.53 (2.35 – 25.04)
ALT	1.71 (0.90 – 4.13)
AST	0.97 (0.53 – 3.12)
Aldolase	3.12 (2.35 – 8.30)

median in months (IQR)

Conclusion: Our cohort of JDM patients had more calcinosis compared to other Asian population². Malay population is at higher risk of this complication. It is crucial to achieve ID state in the shortest time possible to avoid significant morbidity. Our study suggests that early treatment with pMP is associated with shorter time to ID. There is no predictor identified for disease course, similar to previous studies³.

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AB1005 BULLOUS LUPUS (BSLE) AS THE FIRST MANIFESTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS IN THE PEDIATRIC POPULATION (PSLE): A DIAGNOSTIC CHALLENGE IN DAILY PRACTICE

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Background: Cutaneous manifestations are observed in 59–85% of patients with SLE but less than 5% developed BSLE. In the GLADEL cohort, the prevalence is 0.41%. BSLE literature in children is scarce

Fig 1. Histology and DIF of BSLE H-E a and b: subepidermal blisters c and d: abundant neutrophils are observed e: DIF full house linear pattern