IgG4-RD were approved by ACR and EULAR in 2019. Whether this new criteria improve the diagnosis efficiency needs to be validated in clinical practice.

Objectives: To apply the 2019 ACR/EULAR classification criteria for the diagnosis of IgG4-RD in previously suspected patients and explore the clinical characteristics of patients with IgG4-RD according to the new classification criteria.

Methods: Patients suspected of having IgG4-RD due to elevated serum IgG4 and swelling or masses in single or multiple organs were recruited in Sun Yat-Sen Memorial Hospital, Sun Yat-Sen University from May 2013 and November 2019. Demographic and clinical data were collected. The diagnosis was reevaluated with the 2011 comprehensive diagnostic criteria (CDC) for IgG4-RD and the 2019 ACR/EULAR classification criteria for IgG4-RD, respectively.

Results:

- There were 68 patients recruited and 59(86.8%) of them had elevated serum IgG4 ($\geq 135\text{mg/dl}$) and 53(77.9%) patients showed swelling or masses in single or multiple organs. Most patients first visit general surgery (17.6%), gastroenterology (16.2%), respiratory medicine (16.2%) and rheumatology (14.7%).
- According to the 2011 CDC for IgG4-RD, 4(5.9%) patients were definite IgG4-RD, 1(1.5%) was probable and 42(61.8%) were possible. According to the 2019 ACR/EULAR criteria, 20(29.4%) patients were diagnosed as IgG4-RD, including the 4 definite patients using the 2011 CDC.
- Among the 20 IgG4-RD patients according to the 2019 ACR/EULAR criteria, 19(95.0%) were male and median age of symptom onset was 62(46–69) years. There were 6(30.0%) patients diagnosed at rheumatology, 5(25.0%) at gastroenterology, 3(15.0%) at general surgery, 2(10.0%) at respiratory medicine and 1(5.0%) at stomatology, endocrinology, orthopedics and urinary surgery, respectively. There were 9(45.0%) patients with bilateral lacrimal or salivary glands involved, 9(45.0%) with pancreas and biliary tree involved, 5(25.0%) with retroperitoneum involved, 2(10.0%) with kidney involved and 1(5.0%) with chest involved.
- The median serum IgG4 of the 20 IgG4-RD patients was 15.40(4.14–55.10) g/L, median serum IgG was 27.9(17.2–50.2)g/L. There were 20.0%(4/20) patients had elevated serum eosinophil and 93.3%(14/15) had elevated serum IgE. There were 60.0%(9/15) patients had elevated C-reactive protein, 85.7%(12/14) had elevated erythrocyte sedimentation rate and 26.7%(4/15) had hypocomplementemia. There were 35.7%(5/14) patients had positive rheumatoid factor and 14.3%(2/14) had positive antinuclear antibodies. There were 6(30.0%) patients didn't received biopsies, 8(40.0%) patients received surgical removal of salivary glands, lacrimal glands or pancreatic masses and 6(30.0%) patients received needle biopsies of the salivary glands or biopsies by bronchoscopy, gastroscopy or enteroscopy.
- Among the patients didn't fulfill the 2011 CDC and the 2019 ACR/EULAR criteria, there were 40 patients had elevated serum IgG4, whose serum IgG4 level were significant lower than those of IgG4-RD patients [3.66(2.39–7.68) g/L vs. 15.40(4.14–55.10)g/L, $P<0.001$], and percentage of serum IgG4 $\geq 5\times$ upper limit of normal were also lower than those of IgG4-RD patients (27.5% vs. 73.7%, $P=0.002$).

Conclusion: The 2019 ACR/EULAR criteria can help diagnosing patients with IgG4-RD even lacking the tissue confirmation. Patients with moderately elevated serum IgG4 need more clinical evidence to diagnose IgG4-RD and exclude mimics.

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AB1021

CHARACTERISTICS AND MANAGEMENT OF RHEUMATIC MANIFESTATION UNDER ESTROGEN RECEPTOR-TARGETING CANCER THERAPIES, DATA FROM A PROSPECTIVE REGISTRY

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Background: The knowledge about interdependencies between rheumatic manifestations and malignancies is limited. Further, reliable data on the occurrence of rheumatic symptoms as side effects of specific cancer therapies beyond checkpointinhibitor-induced immune-related adverse events are sparse. In this regard, although arthralgia under estrogen receptor-targeting therapies (aromatase inhibitors and the estrogen receptor modulator tamoxifen) has been frequently reported in oncological clinical trials and case reports, prospective

data including an assessment of rheumatic manifestations by rheumatologists are lacking.

Objectives: To contribute to a better understanding of interdependencies between rheumatic manifestations and cancer/ estrogen blockade and potentially improve the management of both entities, pilot data were analysed.

Methods: Data on characteristics and treatment of rheumatic manifestations and cancer as well as their timely association were systematically, prospectively collected and analysed in the Malheur ('malignancy and rheumatic disease') registry, a long-term, observational study designed to study patients suffering from concomitant rheumatic disease and malignancy and/or premalignant lesions.

Results: We identified 11 patients with rheumatic manifestations under estrogen receptor-targeting therapies (3 anastrozol, 4 letrozol, 8 tamoxifen) as part of breast cancer treatment. In addition to breast cancer one patient had a lymphoma 3 years after and another patient had a non-small cell lung cancer 2 years before breast cancer diagnosis. The patients had different cancer stages (5 IA, 3 IIA, 1 IIB, and 1 IVA). Their mean age at cancer diagnosis was 60.4 ± 11.6 years and all patients are females. The time interval between diagnosis of cancer and onset of systemic/ rheumatic symptoms was 49.5 ± 34.0 months. Of interest, the time interval between onset of rheumatic symptoms and first assessment by a rheumatologist was 16.9 ± 22.3 months. The following systemic and rheumatic symptoms were reported: arthralgia in 10, arthritis in 8 (small joints in 5, large joints in 3 affected), morning stiffness ($>30\text{min}$) in 7, IBP in 1, myalgia in 7, sicca symptoms in 2, fever in 1 (new-onset FMF with heterozygous M694U mutation), class IV glomerulonephritis and polyserositis in 1 (with new-onset SLE) patient(s). Disease burden at baseline was rather high with a mean VAS pain of $65 (\pm 12.9)/100$. Laboratory analyses revealed an increased CRP in 6/11 (55%) with a mean of $10.3 \pm 8.2\text{mg/l}$ (<5). Autoantibody positivity was observed for ANAs in 5/10 (50%, titers ranging from 1:80 to 1:160), anti-dsDNA in 1, rheumatoid factor in only 1/10 (10%) patients, none was anti-CCP positive. Before consulting a rheumatologist, patients were treated with NSAR 3/11 (27%), 10/11 systemic glucocorticoids (91%) with an initial dose of $17.5 \pm 19.5\text{mg}$ and intra-articular glucocorticoids 1/11 (9%). Rheumatological assessment lead to initiation of csDMARDs (3/11 MTX, 1/11 SSZ, 1/11 HCQ, 1/11 AZA (later MMF/ rituximab in the SLE patient) 1/11 colchicine) as corticosteroid-sparing agents with good response in the majority of patients.

Conclusion: Our data demonstrate heterogeneous rheumatic manifestations, partially with severe manifestations beyond arthralgia, so far not reported by oncological studies including follow-up, which might suggest an underreporting. Furthermore, despite close monitoring in tumor aftercare, our data show a considerable delay in referral to a rheumatologist and initiation of suitable treatment. The prospective design of the Malheur registry enables future validation of our pilot data.

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AB1022

PANNICULITIS IN RHEUMATOLOGICAL PRACTICE: THE RESULTS OF LONG-TERM FOLLOW-UP

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Background: Panniculitis is a group of heterogeneous inflammatory diseases that occur with damage to the subcutaneous fat (SCF), musculoskeletal system, and often internal organs

Objectives: to evaluate the course and outcome in patients with panniculitis

Methods: the course of the disease was monitored in 193 patients treated at the V.A. Nasonova Research Institute of Rheumatology for 3-5 years (142 women, 51 men) aged 19 to 77 with the referral diagnosis of erythema nodosum (EN) and