Conclusion: Anti-IL-1 drugs are the best maintenance treatment in TRAPS with limited effect on long-term outcomes.

Methods: We reviewed all data on patients with TRAPS enrolled in the Eurofever international registry according the INSID gene variant classification and the new Eurofever/PRINTO classification criteria (EPCCC).

Results: Data on 226 patients were available. Patients not fulfilling the EPCCC carrying likely benign/benign variants (21 patients, 9%) or VOUS/not classified variants (21 patients, 9%) or VOUS/not classified variants not fulfilling the EPCCC. Data on 226 patients were available. Patients not fulfilling the EPCCC carrying likely benign/benign variants (21 patients, 9%) or VOUS/not classified variants (21 patients, 9%) or VOUS/not classified variants not fulfilling the EPCCC.

Objectives: The study included 2 groups of sJIA patients: stable remission (Remission group, n=53) or received CAN (n=10) or TOC (n=43) treatment, and in acute stage of disease (Acute group, n=25) which started to receive CAN (n=7) or TOC (n=18) either before vaccination (Acute Treated Before subgroup, n=17) or after vaccination (Acute Treated After subgroup, n=8). The study included 2 groups of sJIA patients: stable remission (Remission group, n=53) or received CAN (n=10) or TOC (n=43) treatment, and in acute stage of disease (Acute group, n=25) which started to receive CAN (n=7) or TOC (n=18) either before vaccination (Acute Treated Before subgroup, n=17) or after vaccination (Acute Treated After subgroup, n=8). The study included 2 groups of sJIA patients: stable remission (Remission group, n=53) or received CAN (n=10) or TOC (n=43) treatment, and in acute stage of disease (Acute group, n=25) which started to receive CAN (n=7) or TOC (n=18) either before vaccination (Acute Treated Before subgroup, n=17) or after vaccination (Acute Treated After subgroup, n=8).

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Background: Juvenile dermatomyositis (JDM) is a systemic, autoimmune inflammatory muscle disorder and vasculopathy that affects children younger than 18 years. Although the cause of JDM remains unknown it is clear that genetic and environmental influences play a role in the aetiology. New treatments are becoming available and being tested through international multicentre trials. Increasing evidence suggests a role for types I and II IFN in juvenile and adult dermatomyositis, including elevated IFN-response gene signatures in the muscle, skin and blood. It has recently been reported that patients with refractory JDM responded well to treatment with tocitabin, a JAK inhibitor, with corresponding downregulation in selected IFN-response genes.

Objectives: In this study, we evaluated our cases with resistant JDM who received tofacitinib treatment.

Methods: Six patients who received tofacitinib because of severe skin involvement of JDM were included in the study. The data were obtained retrospectively from the hospital records.

Results: The age ranges of the cases were between 7-17 years and the ratio of girls and boys was 1 (3/3). The age of diagnosis was between 2-13 years, and the follow-up period was between 3-9 years. Calcification cuts in 5 cases, decreased muscle strength in 3 cases, joint involvement in 4 cases were detected. Steroidal systemic, methotrexate, and non-steroidal anti-inflammatory drugs were given in all cases before tofacitinib treatment. Pamidronate was used in 4 cases because of severe skin calcinosis, high dose intravenous immunoglobulin in 4 cases, myco- phenolate mofetil in 3 cases, rituximab in 3 cases and cyclophosphamide in 1 case previously. Tofacitinib treatment (10mg/gün) was started in six cases with treatment-resistant JDM. Five cases had been treated with tocitabin for 6-24 month intervals. The treatment was discontinued in one case because of severe allergic reaction. Variable level of improvement were detected in the skin findings of all cases during the therapy period. The treatment was interrupted for 1 month in only one case due to neutropenia.

Conclusion: Tocafitinib seems to be an effective and safe treatment option in patients with JDM who are resistant to conventional treatments. More studies are needed on this subject.

Disclosure of Interests: None declared

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SAFETY OF BIOLOGICAL AGENTS IN JUVENILE IDIOPATHIC ARTHRITIS: A META-ANALYSIS OF OBSERVATIONAL STUDIES


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Background: Follow-up cohorts (observational studies) were initiated consecutively or simultaneously to the development of randomised controlled trials (RCTs) in JIA patients 1,2,3,4,5,6. They help to identify many complications observed only in clinical practice, play a role in the aetiology. New treatments are becoming available and being tested through international multicentre trials. Increasing evidence suggests a role for types I and II IFN in juvenile and adult dermatomyositis, including elevated IFN-response gene signatures in the muscle, skin and blood. It has recently been reported that patients with refractory JDM responded well to treatment with tocitabin, a JAK inhibitor, with corresponding downregulation in selected IFN-response genes.

Objectives: To estimate the incidence of serious adverse events (SAEs) including serious infections, malignancies, and death in patients with juvenile idiopathic arthritis (JIA) treated with biological agents (BAs) in daily clinical practice, using meta-analysis techniques.

Methods: We systematically searched, up to May 2019, Medline and Embase databases for observational studies performed in JIA disease under BAS treatment. Outcomes were SAEs, serious infections, malignancies and all-cause mortality. Complementary, the incidence of SAEs in randomised controlled trials (RCTs) with withdrawal and parallel designs was performed by meta-analysis.

Results: A total of 31 observational studies were included (6811 patients totalizing 17530 patients-years [PY] of follow-up). The incidence rate of SAEs was similar in observational cohorts and withdrawal RCTs (4.46 events per 100 PY, 95% CI 2.85-6.38, I2= 95%) and 3.71 events per 100 PY (95%CI 0.00-13.34, I2= 56%), respectively. The incidence of SAE was lower in parallel RCT. The incidence rate of serious infections, malignancies and death in observational cohorts was estimated at 0.74 events per 100 PY (95%CI 0.32-1.30, I2=83%), 0.10 events per 100 PY (95% CI 0.06-0.16, I2=0%) and 0.09 events per 100 PY (95% CI 0.05-0.14, I2=0%), respectively. Infections were the known cause of death in 8 of the 14 deaths. In meta-regression and subgroup analysis, variation of serious infections rates were partially explained by follow-up time (R2 = 30.3%, p = 0.0008). JIA categories (all JIA versus polyarticular versus systemic JIA categories, p= 0.001) and cohort quality (Newcastle-Ottawa score ≥ 6 versus ≤ 5 stars, p = 0.0025).

Conclusion: Our results suggest that the incidence rate of SAE related to BAS in JIA disease is similar to those observed in randomised withdrawal trials. The overall incidence remained low. However, unsatisfactory description of SAEs prevents analysis of hospitalisation causes. Infection and, to a lesser extent, cancer and death, explain only part of burden of BAS.

References:

Disclosure of Interests: None declared

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FRI0461

THE ANTI-VACCINE ANTIBODY AGAINST MEASLES, PAROTITIS, RUBELLA, DIPHTHERIA AND HEPATITIS B IN 170 JUVENILE IDIOPATHIC ARTHRITIS PATIENTS

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Background: Patients with juvenile idiopathic arthritis (JIA) may have lower protective levels of anti-vaccine antibodies due to high inflammatory activity, interrupted or incomplete vaccination schedule, and due to using of immune-modulating drugs, e.g. systemic corticosteroids (CS), methotrexate (MTX) and biologics.

Objectives: The aim of our study was to find the predictors of low levels of anti-vaccine antibodies in patients with JIA.

Methods: In the present study we included data 170 JIA (55 boys and 115 girls) aged from 2 to 17 years, who received scheduled vaccination before the age of 2 years and before JIA onset against measles, parotitis, hepatitis B, diphtheria and rubella. In all patients the lg G anti-vaccine antibodies levels were detected with ELISA. In each patient we evaluate the type of the disease (oligoarthritis - 73, polyarthritis - 61, systemic-16 and enthesitis-related arthritis - 20), onset age, presence of uveitis, duration of JIA, treatment with corticosteroids (CS), methotrexate (MTX) and biologics. Data presented with median and 25%-75%.

Results: The main demographic characteristics: age of inclusion in the study 11.4 (76-14.8) years, disease onset – 6.0 (3.7-9.0) years, disease duration – 3.8 (1.9-6.5) years. Treatment with CS was in 43 (25.3%), MTX in 154 (90,6%) and biologics 82 (48.2%) patients, among them 53 had TNFa-inhibitors. More than 1 biologic consequently received 16/82 (19.5%) patients. Protective levels of anti-tetanus – 167 (98.8%). Data of vaccination status and anti-vaccine antibodies levels are presented in table. In univariate and multivariate regression analysis the main risk factors for anti-measles antibodies levels were MTX using (p=0.045), more than 1 biologicos (p=0.0004); for anti-hepatitis B – MTX (p=0.03), for anti-diphtheria antibodies: onset age (p=0.0002). JIA duration (p=0.0007), number vaccine doses (p=0.02), more than 1 biologics (p=0.01); combined treatment with biologics and other drugs (MTX or CS).