articular and extra-articular damages and the need for prosthetics and the psychological status.

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FRI0493
THE INTERLEUKIN-1B INHIBITOR CANAKINUMAB FOR REFRACTORY STILL’S DISEASE: LONG-TERM EXPERIENCE IN 50 CONSECUTIVE PATIENTS


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Background: Interleukin-1 (IL-1) is a major mediator of the inflammatory cascade in Still’s disease and an established therapeutic target.

Objectives: To assess the efficacy and safety of the IL-1b inhibitor canakinumab in adolescent and adult patients with refractory Still’s disease.

Methods: We conducted a retrospective longitudinal outcome study of 50 consecutive patients (median age 23 years, median disease duration 12 years, Range 6-67 years), fulfilling the Yamaguchi classification criteria, with active disease despite treatment with corticosteroids (CS) (n=11) and/or methotrexate (n=9) and/or biologics (n=30) [tumor necrosis factor inhibitors (n=13), IL-6 blockade (n=7), abatacept (n=2), anakinra (n=24); b1 biologics (n=13)]. Canakinumab 150-300 mg was administered sc, starting every 4 (n=48) or 8 weeks (n=2), for a median of 24 months (range 3-84). Concomitant treatment included CS (n=41), methotrexate (n=12) and leflunomide (n=5).

Results: Complete remission was initially achieved in 78% of patients within a median time of 3 months, irrespective of age at disease onset. Partial clinical and laboratory response was evident in 20%. Canakinumab was discontinued in one patient with resistant disease (primary failure) and in 6 out of 10 initial responders, who relapsed during treatment (secondary failure). Of 39 patients in complete remission, increase in drug administration interval and/or drug dose reduction was attempted in 7 of which only 1 relapsed, whereas drug discontinuation was attempted in 19 patients for a median time of 8 months (range 3-68), of which 8 relapsed. Overall, in half of all disease flares, canakinumab re-introduction or intensification was successful. Canakinumab had a significant CS sparing effect permitting weaning in 21 of 41 cases. Partial clinical and leflunomide (n=3).

Conclusion: In one patient.

Disclosure of Interests: None declared

FR0494
RHEUMATIC IMMUNE RELATED ADVERSE EVENTS OF CHECKPOINT INHIBITORS: A RETROSPECTIVE REVIEW OF 70 PATIENTS

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Background: Immune checkpoint inhibitors (ICI) have revolutionized cancer therapy by achieving remarkable survival benefits however, at the cost of a myriad of immune-related adverse events (irAEs)[1]. Rheumatic irAE can develop in 5-10% of patients although the true incidence is unknown given the lack of prospective studies [2]. Symptoms are heterogeneous and probably underreported with few data available about their management and outcome [3].

Objectives: To describe the clinical, biological, and radio logical features of the largest cohort of rheumatic irAEs from ICI along with their therapeutic management, outcome and follow-up in real-world practice.

Methods: A referral process for emergent rheumatic irAEs was initiated in February 2016 between the oncology and rheumatology departments at the Cleveland Clinic Foundation. All patients were evaluated by authors CC and/or LHC. Patients’ characteristics were retrospectively collected from medical charts after IRB approval.

Results: 70 patients referred for one or more rheumatic irAEs between February 2016 and January 2020 were included. 66% were male, median age was 60.8 years. Among them, 24 (34%) had pre-existing rheumatic complaints. Melanoma was the most frequent malignancy (56%). ICI therapy included anti-CTLA4 (40%), anti-PD1/PD-L1 (79%), and dual therapy ipilimumab/nivolumab (41%). Rheumatic irAE occurred in a median 4 months after ICI initiation, with phenotypes including inflammatory arthritis (32 patients), sicca-like symptoms (12), polymyalgia rheumatica-like (7), and myositis (2). Oral, intravenous or intraarticular glucocorticoids (GC) were administered to 54 patients (77%). Of these 54 patients, 22 (41%) required long term GC, 19 had bone density scan and 15 received pneumocystis (PJP) prophylaxis. One PJP case, 1 osteoporo tic fracture and 2 avascular necrosis cases were reported. 16 patients received conventional DMARDS (23%) and 9 received biologics (13%). ICI therapy was held for rheumatic irAE in 31% of cases and for another systemic irAE in 29%. Median follow-up was 13.6 months, at end of follow-up 51 patients were still on treatment for rheumatic irAE and 41% of them were still symptomatic despite ongoing treatment.

Conclusion: Rheumatic irAEs are heterogeneous and often chronic requiring prolonged immunomodulatory therapy. Prospective studies are required to define optimal management of rheumatic irAEs that maintain long-term oncologic outcomes.

References:

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