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AB0734

REMISSION IN JUVENILE IDIOPATHIC ARTHRITIS AFTER WITHDRAWAL OF SYSTEMIC TREATMENT

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Background: Juvenile idiopathic arthritis (JIA) requires frequent systemic treatments, the ideal goal being to achieve remission. Questions remain as to when treatment can be stopped and how to balance the risks and benefits of continuing medications against the possibility of a flare after discontinuation. There is currently little conclusive evidence on the management of JIA in remission.

Objectives: To determine the time to remission and frequency of flares in patients with JIA after withdrawal of systemic treatment in a single-centre cohort.

Methods: Patients with JIA visited in the last 15 years were included. A retrospective cross-sectional study was performed. Demographic data such as sex, age at diagnosis, current age, subcategories of JIA were collected. Systemic treatment was also collected (date of discontinuation, date of flare after discontinuation, time in remission, time of treatment until discontinuation, discontinuation of biologic therapy while maintaining methotrexate). For the analysis of qualitative variables, absolute and relative frequencies were used; for quantitative variables, median and IR; for comparative analysis, Chi-square and Mann-Whitney U test.

Results: We included 146 patients with JIA. Demographic data are shown in Table 1. 134 (90.4%) patients required systemic treatment (synthetic and/or biological DMARDs), of which 61 (45.5%) discontinued treatment completely at some point. Of the total number of patients who discontinued all systemic treatment, 19 (31.1%) had a flare with a median time in remission of 4.1 years (IR 1.3-9.1), 17 of the 134 patients (12.7%) with systemic treatment discontinued biologic therapy while maintaining methotrexate, of which 12 (70.6%) patients had a flare with a median time in remission of 0.9 years (IR 0.6-1.2). The differences between the frequency of flares and median time in remission between both treatment discontinuation groups (all systemic treatment versus discontinuation of biologic while maintaining methotrexate) were statistically significant ($p < 0.001$). The median time from systemic treatment to complete withdrawal was 3.2 years (IR 1.9-4.8).

Table 1. Demographic characteristics of patients with JIA

Variables	N 146
Sex: Women n (%)	89 (60.3)
Age at onset (years, median (IR))	4.6 (2.5-9.2)
Current age (years, median (IR))	16.7 (11.1-20.9)
Types of JIA:	
Persistent oligoarticular n (%)	66 (45.2)
Extended oligoarticular n (%)	11 (7.5)
Polyarticular RF - n (%)	29 (19.9)
Polyarticular RF + n (%)	3 (2.1)
Enthesitis-related n (%)	12 (8.2)
Psoriatic n (%)	9 (6.2)
Systemic n (%)	16 (11.0)

Conclusion: One third of the patients in whom all systemic treatment was withdrawn had a flare (70% remain in remission without medication) with a median time in remission of 4 years. On the other hand, two-thirds of patients in whom biologic therapy was withdrawn while maintaining methotrexate had a flare, with a shorter time in remission. The differences between both groups with withdrawal of systemic treatment are statistically significant ($p < 0.001$).

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AB0735

POLYMORPHISMS OF GENES CD14, C-REACTIVE PROTEIN, FIBRINOGEN BETA CHAIN, ASSOCIATED WITH THE DEVELOPMENT OF KAWASAKI DISEASE AND CORONARY ARTERY ANEURYSMS IN CHILDREN FROM CENTRAL RUSSIA

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Background: Kawasaki disease (KD) is a multifactorial disease with a genetic predisposition, systemic vasculitis complicated by the formation of coronary artery aneurysms (CAA). Its pathogenesis is based on immune inflammation with an increase in the concentration of pro-inflammatory cytokines, the level of C-reactive protein (CRP), and coagulation disorder.

Objectives: to search for polymorphisms of genes cluster of differentiation CD14, CRP, fibrinogen beta chain (FGB), associated with the KD development and a predisposition to the CAA formation among patients with KD living in Moscow and the Moscow region.

Methods: genotyping for gene polymorphisms CD14 -159 C>T (rs2569190), CRP 3872 C>T (rs1205), FGB - 455 G>A (rs1800790) by PCR in 31 children 1 month - 10 years old (median age 19 months [9.0; 38.5]) with KD, among them, in 10 patients the disease was complicated by CAA formation according to echocardiography, and 30 children of the control group.

Results: Three out of six investigated SNPs showed statistically significant difference in genotype and allele distribution: CRP C3872T, CD14 C159T and FGB G455A. CRP gene polymorphism: in patients with KD significantly less frequent is homozygous type TT (RR 0.22, 95% CI: 0.05-0.91, $p = 0.0168$).

CD14 gene polymorphism: in control group heterozygous genotype CT is predominant, (RR 0.58, 95% CI: 0.4-0.83, $p = 0.0017$) among patients with KD homozygous genotypes CC and TT are predominant. (RR 3.61, 95% CI: 1.14-11.49, $p = 0.0057$).

FGB gene polymorphism: genotype GA is predominant in control group (RR 0.48, 95% CI: 0.26-0.9, $p = 0.0149$). In patients with KD significantly less frequent is homozygous type GG (RR 1.69, 95% CI: 1.03-2.8, $p = 0.0297$).

We didn't find any significant difference in genotype and allele distribution in KD patients with and without CA lesions.

Conclusion: statistically significant differences ($p < 0.05$) were revealed in the distribution of genotypes for polymorphisms of the CD14 -159 C>T, CRP 3872 C>T and FGB -455 G>A genes among patients with KD and children of the control group; when comparing the results of KD patients with CAA and the control group, statistically significant differences ($p < 0.05$) were revealed only in the polymorphism CD14 -159 C>T. It can be assumed that these polymorphisms are associated with the development of KD and CAA in these patients.

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AB0736

JUVENILE IDIOPATHIC ARTHRITIS IN ADULTHOOD: TRENDS OF THE DISEASE AND SOCIO-PROFESSIONAL FUTURE

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Background: Juvenile idiopathic arthritis (JIA) is the most common arthropathy of childhood that may lead to physical disability and reduced quality of life, thus hindering the ability of the patients to achieve a meaningful adult life.

Objectives: The aim of this study was to assess the trends of the disease and socio-professional future.

Methods: We conducted a retrospective study including adult patients aged > 18 years with a history of JIA according to the International League of Associations for Rheumatology (ILAR). Collected data included age, sex, the