Background: Interstitial lung disease is a well described extra-articular manifestation in a range of rheumatic diseases. It carries significant morbidity and mortality. Management of rheumatic diseases associated ILD (r-ILD) requires expertise as the needs of such patients are complex and treatment options limited. Historically, such complex ILD has been managed in tertiary referral centres. We set up a combined service incorporating both rheumatology and respiratory domains in a district general hospital (DGH) to help patients avoid long journeys and improve their experience whilst focusing on an integrated care pathway.

Objectives: We evaluated the outcomes of all patients managed over three years in this pilot service model.

Methods: Referrals were accepted from any hospital specialist involved in the management of r-ILD. They were triaged by lead ILD pulmonologist to monthly ILD MDT comprising a rheumatologist, respiratory physician, a radiologist and ILD specialist nurse. Appropriate patients were booked into combined clinic, run by the respective rheumatologist and chest specialists with ILD interest, attracting a multi-specialty tariff. All the data was recorded electronically with full access to demographics, disease parameters, investigations and drug management.

Results: 111 consecutive patients were included in this evaluation. Mean age was 66.4 yrs (19-92 yrs) and 36% (n=40) were male. 34 (30%) had RA, 31 (28%) had CTD, 20 (18%) had IPAF and 26 others. Most predominant HRCT pattern was NSIP (n=40,36%) followed by UIP (n=31, 28%). Mean FVC was 2.59 L/min (1.93-4.13) with DLCOc of 52.7% (28.9-90.1%) predicted. Only two patients had all antibodies negative whilst 109 had at least one antibody positive with ANA being the most common (n=38).

Most (83%) patients were treated with immunomodulators including 11 with rituximab. 49 (44%) patients had significant improvement in clinical, imaging and pulmonary parameters with DLCoC improving to 56.57% and FVC to 2.70 L/min. There were similar improvements in six minute walk test. 21 patients died and 23 patients required long term oxygen therapy.

Conclusion: This pilot real world study confirms the utility of a combined specialist service in a district general hospital. Nearly half of this complex and resource intensive patient cohort had good clinical outcomes and derived benefit from the expertise in one room. Feedback from both patients and referrers was unanimously positive. No patient required tertiary centre referral and all could be managed adequately in the clinical setting.

Our report confirms that r-ILD can be managed in a DGH setting with a stream-lined service offering clear benefits to patients. We would argue that r-ILD service, congruent to satellite pulmonary hypertension clinics in secondary care with hub-and-spoke model liaison with tertiary centre, can be established on similar principles and could help over-stretched tertiary care with repatriation of services whilst helping develop local expertise in the management of chronic ILD.

Disclosure of Interests: None declared

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ADVERSE EVENTS UNDER B-CELL DIRECTED THERAPIES IN A LARGE SINGLE-CENTER COHORT OF PATIENTS WITH RHEUMATOID ARTHRITIS, SYSTEMIC LUPUS ERYTHEMATOSUS, ANCA-ASSOCIATED VASCULITIS AND RENAL DISEASES

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Background: The anti-CD20 antibody rituximab (RTX) is approved for the treatment of rheumatoid arthritis (RA) and ANCA-associated vasculitis (AV). In addition, RTX is used in a wide range of autoimmune diseases. Belimumab (BEL) is an anti-BAFF antibody approved for the treatment of non-renal systemic lupus erythematosus (SLE) in Europe. These agents are generally well-tolerated but severe adverse events (AEs) can occur. The frequency of and factors associated with AEs are currently unknown.

Objectives: To identify adverse events with the use of B-cell directed therapies in a large population of RA, AAV, and SLE.

Methods: This is a single-center retrospective cohort study using routine clinical data over a ten-year period (2010-2020). We recorded epidemiological and clinical data of patients receiving either BEL or RTX. Data included age, gender, type of disease, number and efficacy of infusions, patient-years and concomitant treatment. Patient records were screened for AEs, such as infections, anaphylaxis, occurrence of malignant disease, laboratory abnormalities and immunoglobulin (Ig) deficiency. Between group comparisons were performed.

Results: A database screening yielded 445 patients treated with RTX and 23 with BEL. After exclusion of patients with incomplete data, 425 RTX and 23 BEL patients were analyzed.

Our preliminary analysis of a sample of 60 of these 448 patients (184 patient-years) resulted in 43 patients (72%) with RA, 8 patients with AAV (13%), 5 patients with a renal disease, and 4 patients with mixed connective tissue disease, as well as 23 SLE patients. Our statement is that at least 14 treatments of 1000 mg were administered, corresponding to 3.37 patient-years per patient. Primary non-response occurred in 2 patients, secondary non-response in 13 patients. For AAV, a median of 8.4 treatments were given (3.3 patient-years), no treatment failure was detected. SLE patients received a median of 15 treatments.

15 patients had infectious complications during treatment, 11 needed treatment. Herpes zoster infection occurred in 3 patients with RA. Three of the 8 patients with AAV had an infection requiring treatment. In SLE patients, only 2 developed infectious complications, and no Ig-deficiency occurred.

Conclusion: No serious or life-threatening events occurred in the patient cohort. No differences were observed when comparing RTX and BEL. However, the frequency of severe and life-threatening events was similar in RA and SLE patients with comparably low numbers of events compared to previously reported results. Other severe infections were observed, mainly gastrointestinal infections, herpes zoster infections, and neutropenia.

Disclosure of Interests: None declared

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