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 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 rheumatology and chest specialists with ILD interest, attracting a multi-speciality 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 (44.1%) 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

DOI: 10.1136/annrheumdis-2021-eular.1102

AB0818

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 (AAV). 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: 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 23 SLE patients. 46 (77%) were female. In RA, a median of 13 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.

Lymphopenia was the most common laboratory abnormality detected in 25 patients with RTX, 19 of whom had RA. Ig deficiency was common in RA, affecting 30% of patients. Deficiency of IgM and IgG was recognized in 5 patients each; 1 patient had low levels IgA.

Neither the maintenance prednisolone dosage nor Ig deficiency were associated with risk for infection. However, lymphopenia appeared to be associated with risk for infection.

Conclusion: Our preliminary data observe a 184 patient-year period. RTX and BEL were generally associated with few AEs. RA patients frequently had laboratory abnormalities (lymphopenia, Ig-deficiency) which did not necessarily translate to clinical events. Infections were more common in AAV, BEL was the best tolerated B-cell directed agent. Overall, our data are reassuring, but we suggest a more careful vigilance in AAV patients.

Disclosure of Interests: Jan-Gerd Rademacher: None declared, Viktor Korendovych: None declared, PETER KORSTEN Speakers bureau: Abbvie, Sanofi Aventis, GSK, Chugai, Boehringer-Ingelheim, Novartis, Consultant of: Lilly, Gilead, Boehringer-Ingelheim, Novartis, GSK, Grant/research support from: GSK **DOI:** 10.1136/annrheumdis-2021-eular.1214

AB0819

PROFILE OF RHEUMATOLOGIC EMERGENCIES IN THE DEPARTMENT OF RHEUMATOLOGY OF THE UNIVERSITY HOSPITAL OF IBN ROCHD IN 2019

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Background: Rheumatology is a medical field often referred to as "cool" because of the low frequency of life-threatening pathologies in common practice (1). However, rheumatologists may be solicited to manage situations that are often depicted as urgent from the point of view of the patient.

Objectives: To profile the consultations received in the emergency unit of the Department of Rheumatology of the University Hospital of Ibn Rochd in Casablanca.

Methods: We conducted a retrospective study on the 2019 emergency consultations register of the Department of Rheumatology of the University Hospital of Ibn Rochd, Casablanca. We collected epidemiological, clinical, and therapeutic data.

Results: 407 emergency consultations were carried out in 2019. The average age of the patients was 50.7 (range 14 - 88). 20% of the consultants were 65 years old or older. The sex ratio M/F was 0.4. 95.6% of the patients were from the Casablanca-Settat region. 86.4% of the patients came from the emergency department of the hospital, 10.6% came from other intra-hospital services, and 3% were referred directly to our department. The most represented socio-professional categories were respectively people without professional activity other than retirees (67.6%), followed by intermediate professions (9.7%), executives and higher intellectual professions (5.8%), and retirees (5.3%). Regarding social insurance, 49.4% of the consultants benefited from a public health assistance scheme, 30% had a public health insurance, 14.4% had no health insurance, and 9.9% had a private health insurance. The most frequent reasons for consultation were polyarthralgia (26.8%), oligoarthralgia (18.9%), low back pain (22.6%), lumbar radiculalgia (16.7%), monoarthralgia (11.8%), neck pain (8.1%), cervicobrachial neuralgia (6.4%), monoarthritis (5.4%), polyarthritis (3.4%), and oligoarthritis (2.7%). The general condition of the patients was good in 83% of cases, 5.2% had asthenia, 4.4% had a fever above 38°C, and 3.7% had anorexia. Extra-articular signs were present in 24.7% of cases. At the end of the consultation, a diagnosis could be made in 57.2% of cases. The diagnoses comprised degenerative (51%), inflammatory rheumatic (8.6%), infectious (7.3%), metabolic (6.7%), and tumor (2.1%) pathologies. The main treatments prescribed were level 1 analgesics in 65.6% of cases, non-steroidal anti-inflammatory drugs in 45% of cases, local treatment in 28.9% of cases, symptomatic slow-acting drugs in 21.9% of cases, muscle relaxants in 17% of cases, rest in 12.5% of cases, and supportive orthotics in 11.6% of cases. Regarding the outcomes of the consultants, 75.4% were referred to a conventional hospital