3. Eta neither prevents nor treats U.
4. Topical NSAIDs and G can hardly be recommended as a reliable means for treatment of U without TNF inhibitors and MTX.
5. Systemic NSAIDs neither prevent nor treat JIA-associated U.

REFERENCES:

Disclosure of Interests: None declared
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POS1325
COMPARISON OF THREE DIFFERENT ALGORITHMS FOR THE TREATMENT OF CHILDREN WITH POLYARTICULAR JIA: THE FIRST YEAR AFTER DIAGNOSIS


Background: Various treatment strategies are used for children with newly diagnosed polyarticular JIA. MTX is usually prescribed, sometimes in combination with high-dose intravenous glucocorticoid pulses (HDGC) or multiple injections of IFX. These different approaches were considered in the German consensus-based treatment protocols for polyarticular JIA, they were also the leading therapies in patients with rheumatoid factor-negative polyarthritis (RF-PA) included in the JIA inception cohort ICON.

Objectives: To compare the effectiveness of three different treatment strategies in nearly DMARD-naïve patients with RF-PA.

Methods: Patients with RF-PA who were included in the ICON cohort and received one of the following treatments within the first three months were considered for the analysis: Group 1: MTX + IAGC in >4 joints, Group 2: MTX + HDGC, Group 3: MTX, no IAGC in >4 joints, no HDGC. Propensity score-adjusted group differences in outcomes after one and two years were analysed by linear and logistic regression analyses.

Results: The analysis included data from 150 patients (79% female, mean age 6.7±4.8 years) enrolled in ICON 1.6±1.9 months after the diagnosis of RF-PA, of whom 52 were in Group 1, 54 in Group 2 and 44 in Group 3. Disease activity did not differ significantly between the groups at start (cJADAS-10 16.7±4.7, 15.8±5.7, 15.9±6.5, respectively). Group 2 patients (inactive disease in 56.1% and 53.4% at 1- and 2-year FU) received one of the following treatments within the first three months were considered for the analysis: Group 1: MTX + IAGC in >4 joints, Group 2: MTX + HDGC, Group 3: MTX, no IAGC in >4 joints, no HDGC. Propensity score-adjusted group differences in outcomes after one and two years were analysed by linear and logistic regression analyses.

Results: 3 (13% vs. 2.2% and 3.6%, p=0.101 and 0.131, respectively). At the 2-year FU, patients in Group 1 also had a significantly lower mean height SDS than patients of Group 3 (0.2±0.8) in patients in Group 2 and significantly lower than in Group 3 (0.191). Mean body mass index SDS also differed significantly between the groups at 2-year follow-up. The mean BMI SDS was highest in Group 1 patients (0.2±0.8), differing significantly from Group 2 (-0.3±0.7, p=0.014) and Group 3 (-0.4±1.1, p=0.023).

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POS1326
FAMILIAL PERIODIC FEVER, APHTHOUS STOMATITIS, PHARYNGITIS AND ADEMITS (PFAPA) SYNDROME: IS IT A SEPARATE DISEASE?

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Background: Periodic fever, aphthous stomatitis, pharyngitis, and adenitis (PFAPA) is the most common periodic fever syndrome in the pediatric population. Unlike other periodic fever syndromes, the pathogenesis and genetics of PFAPA is unknown. Until recently, PFAPA was believed to be a sporadic disease, yet family clustering has been widely observed and current research indicates that heredity is likely.

Objectives: To identify demographic and clinical differences between patients with PFAPA who have a positive family history (FH+) compared to those with PFAPA with no family history (FH-) that can reveal heritable and sporadic subtypes of this disorder exist.

Methods: In a database comprising demographic and clinical data of 273 pediatric PFAPA patients treated at two tertiary centers in Israel, 31(14.3%) of patients were PFAPA FH+. Data from patients with FH+ for PFAPA was compared to data from those with FH- of the disorder. Furthermore, family members (FMs) of those with FH+ were contacted via telephone for more demography and clinical details.

Results: FH+ group had more headaches (32% vs.2%; p=0.016), myalgia (56% vs. 19%; p=0.001), higher carrier frequency of M694V mutation (54% vs. 25%; p=0.053), greater family history of FMF (30% vs. 15%; p=0.096) and better outcomes with colchicine (82% vs. 52%; p=0.096) compared to those with FH-. FMs displayed almost identical characteristics to the FH+ group except for greater arthralgia during flares (26% vs. 23%; p=0.038) and compared to the FH+ group, more oral aphtha (68% vs. 43%; p=0.002), myalgia/arthritis (64% vs. 19%;6% vs. p=0.001), and higher rates of FH of FMF (45% vs.15%; p=0.003).

Conclusion: Our findings suggest that FH+ had probably different subset of disease with higher frequency of family history of FMF arthralgia, myalgia and better response to colchicine. Colchicine prophylaxis for PFAPA should be considered in FH+.

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