had at least one sign of cutaneous damage, the most common being calcinosis. In at least one organ using the MDI (MDI ≥1). 38% of the patients (11/29) were used in patients refractory or intolerant to methotrexate. Cyclophosphamide, with good results. Hydroxychloroquine was added in 15 patients with dominant cutaneous manifestations. Mycophenolate mofetil, azathioprine and tacrolimus as a rescue for relapses in 2 patients. Intravenous immunoglobulin was used prior to referral.

Methods: Retrospective review of records and cross-sectional assessment of outcome and damage in 29 patients with JDM at a tertiary hospital in Kochi, India. The disease course was categorized as mononuclear, polymeric and chronic progressive. Cumulative damage was assessed using the IMACS myositis damage index (MDI).

Results: Twenty-nine patients (male:16) diagnosed with definite or probable juvenile dermatomyositis based on the Bohan and Peter criteria and having a minimum follow-up period of 3 years each were enrolled. Of these, 20 children were diagnosed and initiated on treatment at our institute (incidental) and 9 were diagnosed elsewhere and referred to our centre for further management (non-incidental). The mean age at disease onset was 7.01 ± 3.34 years (range: 1.0 to 13.5 years). The median interval from onset to diagnosis was 3 months (range: 3 weeks to 8.75 years). Delayed diagnosis defined as interval from onset to diagnosis exceeding 6 months was noted in case of 8 children. Among patients in the non-incidental group, six were considered to have not received standard of care treatment prior to referral to our centre. Standard of care treatment was defined as initiation of a treatment regimen comprising of glucocorticoids with an immunosuppressive agent within 4 weeks of diagnosis. A total of 11 children had a delayed diagnosis and/or had not received standard of care treatment prior to referral.

At our centre, all patients received oral steroids and subcutaneous methotrexate as standard therapy. Pulse steroids were used to induce remission in 12 patients and as a rescue for relapses in 2 patients. Intravenous immunoglobulin was used in 10 children with severe myositis, ophthalmalgic weakness, refractory cutaneous disease including calcinosis and concomitant infection, where affordable with good results. Hydroxychloroquine was added in 15 patients with dominant cutaneous manifestations. Mycophenolate mofetil, azathioprine and tacrolimus were used in patients refractory or intolerant to methotrexate. Cyclophosphamide and rituximab were used in 4 patients each with refractory disease and extra-muscular manifestations such as intestinal lung disease. Seven patients with refractory calcinosis received pamidronate infusions.

Background: There is paucity of data regarding long-term outcome and cumulative damage in children with juvenile dermatomyositis (JDM) from the Indian subcontinent.

Objectives: To assess the long-term outcome and cumulative damage in children with JDM receiving treatment at a tertiary hospital in southern India.

Methods: Retrospective review of records and cross-sectional assessment of outcome and damage in 29 patients with JDM at a tertiary hospital in Kochi, India. The disease course was categorized as mononuclear, polymeric and chronic progressive. Cumulative damage was assessed using the IMACS myositis damage index (MDI).

Results: Twenty-nine patients (male:16) diagnosed with definite or probable juvenile dermatomyositis based on the Bohan and Peter criteria and having a minimum follow-up period of 3 years each were enrolled. Of these, 20 children were diagnosed and initiated on treatment at our institute (incidental) and 9 were diagnosed elsewhere and referred to our centre for further management (non-incidental). The mean age at disease onset was 7.01 ± 3.34 years (range: 1.0 to 13.5 years). The median interval from onset to diagnosis was 3 months (range: 3 weeks to 8.75 years). Delayed diagnosis defined as interval from onset to diagnosis exceeding 6 months was noted in case of 8 children. Among patients in the non-incidental group, six were considered to have not received standard of care treatment prior to referral to our centre. Standard of care treatment was defined as initiation of a treatment regimen comprising of glucocorticoids with an immunosuppressive agent within 4 weeks of diagnosis. A total of 11 children had a delayed diagnosis and/or had not received standard of care treatment prior to referral.

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Conclusion: Nearly half of the patients had damage in at least one organ using the MDI. Cutaneous damage was the most common, followed by skeletal, muscle, pulmonary and endocrine damage. Longer duration of untreated/sub-optimally treated disease significantly increases the risk of cumulative damage, highlighting the need for an early diagnosis and referral to pediatric rheumatology services.

Disclosure of Interests: None declared

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**LONG-TERM OUTCOME IN CHILDREN WITH JUVENILE DERMATOMYOSITIS FROM SOUTHERN INDIA**

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**ETANERCEPT-ASSOCIATED NEW ONSET UVEITIS IN PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS UNDER BIOLOGICAL THERAPY: SINGLE CENTER EXPERIENCE**

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Background: Biological agents (BA), especially TNF inhibitors, are high efficacy options for current therapy for patients (pts) with juvenile idiopathic arthritis (JIA). They are successfully used not only for the arthritis but also for JIA-associated uveitis, however, development of uveitis de novo in pts treated with BA is a well-established paradoxical phenomenon.

Objectives: to evaluate the frequency of new onset (no-) uveitis, occurring under BA therapy in JIA pts, to establish clinical features, which may be associated with development of such effects.

Methods: retrospective cohort study involved all JIA pts (1136) who were treated with BA in our clinic from 2004 to 2020. All cases of no-uveitis were collected for the describing of their clinical features in disease onset and course, activity level, JIA category, exposure to Methotrexate (MTX) and BA, presence of ANA, HLA B27.

Results: among of 1136 pts treated with different BA we identified 36 (3.3%) pts (19 female/17 male) with no-uveitis under BA. Mostly during etanercept (ETA) therapy (34 cases from 488 ETA courses, 7%, 1/166 - in abatacept (ABA) and 1/372 - in adalimumab (ADA). 30 pts (83%) with no-uveitis developed it on the 1st line of BA treatment (29 ETA vs 1 ADA). 4pts (11%) developed no-uveitis on 2nd line (3 ETA vs 1 ABA). 2 pts (6%) on third line (all ETA, both pts had also psoriasis). There are no cases of no-uveitis under other BA. Frequency of no-uveitis was much higher in ETA group. ETA exposure was 26.8±28.8 months (mo). It means there are no “safe” period of therapy from paradoxical phenomenon of no-uveitis. JIA subtypes were as follows: RF-neg polyarthritis 9 (25%), persistent oligoarthritis 3 (8%), extended oligoarthritis 21 (59%), enthesitis-related arthritis (ERA) - 3 (8%).

Conclusions: no-uveitis is under BA. Mostly during etanercept (ETA) therapy (34 cases from 488 ETA courses, 7%, 1/166 - in abatacept (ABA) and 1/372 - in adalimumab (ADA). 30 pts (83%) with no-uveitis developed it on the 1st line of BA treatment (29 ETA vs 1 ADA). 4pts (11%) developed no-uveitis on 2nd line (3 ETA vs 1 ABA). 2 pts (6%) on third line (all ETA, both pts had also psoriasis). There are no cases of no-uveitis under other BA. Frequency of no-uveitis was much higher in ETA group. ETA exposure was 26.8±28.8 months (mo). It means there are no “safe” period of therapy from paradoxical phenomenon of no-uveitis. JIA subtypes were as follows: RF-neg polyarthritis 9 (25%), persistent oligoarthritis 3 (8%), extended oligoarthritis 21 (59%), enthesitis-related arthritis (ERA) - 3 (8%).