CC motif ligand 2 chemokine (CCL2) were measured in PMR patients and in healthy controls.

**Results:** A total of 25 patients with PMR were studied (32% men; 68% women). The mean age was 72.72 ± 9.32 years (range 65-79). We also included 35 healthy controls. In reference to laboratory parameters and proinflammatory biomarkers at the onset of PMR, the mean values (a standard deviation) were as follows: C reactive protein (CRP): 28.4 ± 26.6 mg/dL; erythrocyte sedimentation rate (ESR): 54.3 ± 23.3 mm/h; haemoglobin: 12.6 ± 1.6 g/dL; IL-6: 17.6 ± 30.1 pg/mL; IL-8: 10.1 ± 6.9 pg/mL; CXCL10: 25.4 ± 29.07 pg/mL; CXCL9: 5175 ± 4398.6 pg/mL; CXCL12: 25.8 ± 12.5 pg/mL; CCL2: 747 ± 152.9 pg/mL. IL-6, IL-8 and CXCL9 levels were significantly increased in PMR patients compared with healthy control group.

The Health Assessment Questionnaire (HAQ) performed at the onset of the PMR yielded a mean value of 1.6 ± 0.6. The mean dose of prednisone employed at the onset of PMR was 14.8 ± 5.6 mg/day. After 6 months, the mean dose of prednisone employed was 6.7 ± 3.9 mg/day, the median [range] value for CRP was 3.1 [1.75-72] mg/dl and the mean value for ESR was 22.14 mm/h. Regarding relationship between proinflammatory biomarkers studied and doses of prednisone employed, no differences were observed.

Regarding pain perception and disability, we observed higher visual analog score values (VAS) in association with higher IL-6 levels (P = 0.03) and higher HAQ values in association with higher IL-6 and CCL2 values. After 6 months, our patients showed an excellent evolution, and no complications were observed.

**Conclusion:** During the acute onset of PMR, IL-6, IL-8 and CXCL9 levels were significantly increased in our population of PMR patients. No differences were observed between proinflammatory biomarkers studied and doses of prednisone employed.

**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2021-eular.3114

**Reference:**

**Disclosures of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2021-eular.3177

**POS1367**

**THE RELATIONSHIP OF MAST CELL ACTIVATION SYNDROME AND HYPERMOBILE EHlers-DANlos SYNDROME IN HOSPITALIZED PATIENTS IN THE UNITED STATES**

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**Background:** Patients with hypermobile Ehlers-Danlos syndrome (hEDS) often report symptoms of cutaneous flushing, pruritis, vomiting, diarrhea and anaphylactoid responses to environmental, food, and mechanical stimuli. There is a growing body of literature investigating the possible link between disorders of connective tissue disorders including hEDS. The evidence for such a relationship, however, remains limited.

**Objectives:** We aimed to evaluate the association between hEDS and MCAS among hospitalized patients using a nationally representative cohort.

**Methods:** Hospitalized patients with a diagnosis of hEDS or MCAS were identified in the 2016-2018 National Inpatient Sample (NIS) using the International Classification of Diseases 10 system (ICD-10). The NIS is an all-payer inpatient database that estimates over 37 million annual U.S. hospitalizations and is maintained by the Healthcare Cost and Utilization Project. The primary outcomes were prevalence of EDS and MCAS among hospitalized patients. Secondary outcomes included cause of admission, mortality, length of stay, and cost of care. Multivariate hierarchical regression analysis was used adjusting for demographics, hospital factors, and comorbid conditions.

**Results:** Among 37,685 patients identified in this study, 35,115 (95.9%) patients had hEDS and 3,630 (9.6%) patients had MCAS. 1080 patients had concomitant hEDS and 3,630 (9.6%) patients had MCAS. 1080 patients had concomitant diagnosis of MCAS. These findings merit further investigation into the co-occurrence of these disease entities and development of consistent clinical diagnostic criteria.

**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2021-eular.3191
and 25% had hyperleukocytosis. 2 patients had already taken antibiotics before admission. Group 2 included 13 patients, their mean PCT was 0.025 ng/mL (0.01-0.13), mean CRP was 132.25 mg/L, mean ESR was 84.38 mm, and 30.77% of them had hyperleukocytosis. Group 3 included 3 patients, their mean PCT was 66.88 mg/L (0.02-200), mean CRP was 560 mg/L, mean ESR was 107.33 mm, and 33.33% had hyperleukocytosis. The patient with the highest PCT was admitted for a sepsis with enigmatic encephalopathy that improved after hemodialysis. A control PCT was made in 2 patients with infection who received antibiotics, showing a decrease or normalization compared to the initial value of PCT.

Conclusion: Our study showed that PCT levels only increased significantly in bacterial infections. The PCT values were more discriminating than the level of WBC and CRP in differentiating a bacterial infection from another inflammatory process, hence the value of using this marker in case diagnosis doubt.

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.3191

POST1368
ANTI-IL-1 THERAPIES IN COLCHICINE-RESISTANT OR INTOLERANT PATIENTS WITH FAMILIAL MEDITERRANEAN FEVER: SINGLE CENTER EXPERIENCE

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Background: Familial Mediterranean Fever (FMF) is a hereditary auto-inflammatory disease characterized by recurrent fever and serosal inflammation (1). The goal of FMF treatment is to prevent the attacks and to minimize subclinical inflammation between attacks. The main treatment of FMF is colchicine however anti- interleukin-1 (anti-IL-1) treatments are recommended in colchicine resistant and/or intolerant FMF patients (2).

Objectives: The aim of this study is to evaluate the efficacy of anti- interleukin-1 (anti-IL-1) agents in 81 FMF patients with resistant/intolerated to colchicine or complicated with amyloidosis.

Methods: Between January 2014 and December 2020, eighty-one patients who were diagnosed as FMF according to the criteria of Tel-Hashomer that following-up at Cumhuriyet University Medical Faculty Rheumatology-Internal Medicine Department were included in to the study.

Results: 45 (55.6%) male and 36 (44.4%) female were included in the study. The median age of the patients was 25 years (min:17-max: 60) and the median age at diagnosis was 15 years (min:3-max: 46). 44 patients (54.3%) used Anakinra (100 mg/day), and 27 (45.7%) canakinumab (150 mg/8 month) were used. 49 cases were resistant to colchicine, 16 were intolerant to colchicine, 16 (20%) patients were treated with leflunomide, 10 patients had renal transplantation. MEFV gene mutations are shown in Table 1. Median duration of anti- IL-1 agent use was 24 month (min:4-max: 52). 9 patients were resistant to anakinra, 18 patients had side effects with anakinra related. After a median follow up 12 months overall clinical response was %95 (frequency of attacks <1/6 months).

Patients had side effects which anakinra related. After a median follow up 12 months overall clinical response was %95 (frequency of attacks <1/6 months).

Conclusion: Anti-interleukin-1 agents are effective and safely in the treatment of FMF patients. There are still unanswered questions in FMF treatment such as other factors affecting the frequency of attacks, colchicine resistance is not defined precisely and the importance of some mutations. The effect of anti-IL-1 agents on FMF patients with amyloidosis is not defined precisely and the importance of some mutations. The effect of anti IL-1 (anti-IL-1) agents on FMF patients with amyloidosis is not clearly. According to our experience, these treatments are effective in patients with glomerular filtration rate>60 ml/min. For answers to these and similar questions, Large and long follow-up studies are needed for long-term effects.

REFERENCES:

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.3280

POST1369
ADULT-ONSET STILL’S DISEASE: A SINGLE-CENTER EXPERIENCE

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Background: Adult-Onset Still’s disease (AOSD) is an autoinflammatory condition characterized by fever, rash, and arthritis. The diagnosis of AOSD is made by excluding common causes of fever of unknown origin which are infections, malignancies, autoimmune conditions and medication adverse effects. As it is a diagnostic challenge, further data on highlighting clinical and laboratory findings are necessary on guiding clinicians.

Objectives: Our main objective is to present our single tertiary center experience of patients diagnosed with AOSD.

Methods: This retrospective study was conducted at a tertiary rheumatology center. Patients were diagnosed with AOSD using Yamaguchi’s criteria and followed between 2007 and 2020. Demographic, clinical and laboratory information was retrieved from the patient charts. Treatment-related and prognostic information were also noted with additional information from phone call interviews.

Results: The study includes 69 patients (23M, 46 F). The mean age of diagnosis was 33.86±14.3. The presenting signs and symptoms of the patients are shown in Figure 1. The laboratory findings supporting the diagnosis at initial encounter are summarized in Table 1. The mean corticosteroid dose at initial diagnosis was 29.7±18 mg. In addition to corticosteroid treatment these patients were followed with different glucocorticoid-sparing agents. Methotrexate was the choice of treatment in 54 patients with the mean dose of 14.5±3.43 mg. Eight patients were treated with leflunomide, seven with anti-TNF agents, seven with tocilizumab, nineteen with anakinra and four with canakinumab.

Figure 1. The presenting signs and symptoms of the patients

Table 1. The laboratory findings at initial encounter

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>Mean ± Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferritin (ng/mL)</td>
<td>3179.46±6503.56</td>
</tr>
<tr>
<td>ESR (mm/h)</td>
<td>7743±28.47</td>
</tr>
<tr>
<td>CRP (mg/L)</td>
<td>102.29±70.39</td>
</tr>
<tr>
<td>Leukocyte Count (cells/L)</td>
<td>13147±3460.9</td>
</tr>
<tr>
<td>ESR (mm/h)</td>
<td>80±28.48</td>
</tr>
<tr>
<td>CRP (mg/L)</td>
<td>105±25±54.67</td>
</tr>
<tr>
<td>Leukocyte Count (cells/L)</td>
<td>12427±14±6530.43</td>
</tr>
</tbody>
</table>

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.3280

POST1370
HYDROXYCHLOROQUINE-INDUCED ATRIOVENTRICULAR BLOCK IN IMMUNE-MEDIATED DISEASES: SINGLE UNIVERSITY CENTER STUDY OF 293 PATIENTS

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Background: Hydroxychloroquine (HCQ) is an extensively used drug in immune-mediated diseases (IMID). Despite its general safety, HCQ can cause serious toxicity such as heart conduction disorders. Atriocentric block (AVB)