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 ng/mL (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 uremic encephalopathy that improved after hemodialysis. A control PCT was made in 2 patients with infection who received antibiotics, showing a decrease or negatization 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.

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POS1368

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 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/intolerant 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 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 (100mg/day), and 27 (45.7%) canakinumab (150mg/8month) were used. 49 cases were resistant to colchicine, 16 were intolerant to colchicine, 16 (20%) cases were complicated with amyloidosis. 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 which anakinra related. After a median follow up 12 months overall clinical response was %95 (frequency of attacks <1/6months). median proteinuria decreased from 3500 mg /day to median 1500 mg /day (p: 0.04) (Table 2). IL-6 treatment was started in 4 patients because of ineffective canakinumab. Five pregnant patients were followed up with anakinra during pregnancy and there were no problems.

Conclusion: Anti-interleukin-1 agents are effectively 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 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.

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POS1369

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

Conclusion: In conclusion, the most common presenting symptoms in our AOSD cohort were fever and salmon-colored rash. In the differential diagnosis of fever of unknown origin especially with rash, AOSD should be considered. Corticosteroid was the main treatment modality. In patients who are unresponsive to conventional immunosuppressive treatment, biologic agents can be an alternative.

Table 1. The laboratory findings at initial encounter

	Mean ± Standard Deviation
Ferritin (ng/mL)	3179.46±6503.56
ESR (mm/h)	77.43±28.47
CRP (mg/L)	102.29±70.39
Leukocyte Count (cells/L)	13147.3±4640.9
ESR (mm/h)	80±28.48
CRP (mg/L)	105.15±54.67
Leukocyte Count (cells/L)	12427.14±6530.43

Disclosure of Interests: None declared

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POS1370

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. Atrioventricular block (AVB)

is an underrecognized adverse effect that can potentially cause significant morbidity and mortality.

Objectives: To study incidence, presentation, and characteristics of HCQ-induced AVB in IMID.

Methods: Open-label single center study of 293 patients with IMID treated with HCQ for at least 3 months. Electrocardiograms were analyzed at baseline and during HCQ treatment. In addition, a comparative study between patients with and without AVB was conducted.

Results: We studied 293 patients (270 women/ 23 men; mean age 59.7±14.7 years). Underlying IMID were Systemic Lupus Erythematosus (SLE) (n=109, 40.6%); undifferentiated connective-tissue disease (n=70, 23.9%), Sjögren's syndrome (SS) (n=70, 23.9%), antiphospholipid syndrome (n=31, 10.6%) and other IMID (n=13, 4.4%). HCQ was used for 4.1±3.5 years.

After 11.8±8.9 years of follow-up (HCQ mean cumulative dose: 979.7±272.1 g). AVB was observed in 19 out of 293 (6.5%) patients: 16 (84.2%) were first-degree AVB and 3 (15.8%) complete AVB. 4 (21.2%) patients with AVB were treated with a permanent pacemaker.

Presentation of atrioventricular block according to hydroxychloroquine incidence rate and treatment duration is shown in Figure 1. Most of AVB happened in the first 40 months, regardless of HCQ cumulative dose.

Figure 1. Presentation of atrioventricular block according to hydroxychloroquine incidence rate and treatment duration.

A comparative study between patients with and without AVB was performed (Table 1). Patients with AVB were older ($p=0.014$) and had a higher incidence of diabetes mellitus ($p=0.033$). HCQ cumulative dose and duration of IMID were similar in both groups ($p>0.05$).

Other HCQ adverse effects were retinopathy (n=16, 5.4%), gastrointestinal alterations (n=14, 4.8%), cutaneous alterations (n=14, 4.8%), allergic reactions (n=4, 1.4%) and myopathy (n=1, 0.3%).

Conclusion: AVB was observed in 6.5% of patients with IMID treated with HCQ. Most AVB were first-degree AVB. HCQ increased the risk of developing an AVB in patients with IMID regardless of HCQ cumulative dose or underlying disease duration. Older patients with diabetes mellitus had a higher risk of developing an AVB.

Table 1. Comparative study between patients with and without AVB.

	with AVB n= 19	without AVB n = 274	p
General features at HCQ onset			
Age, years mean±SD	57.4±14.5	46.4±16.8	0.014
Female, n (%)	17(89.5)	239(87.4)	0.877
Hypertension, n (%)	14 (73.7)	149 (54.4)	0.118
Dyslipemia, n (%)	11 (58.9)	117 (42.7)	0.265
Diabetes Mellitus, n (%)	5 (26.3)	24 (8.7)	0.033
Renal impairment, n (%)	5 (26.3)	29 (10.7)	0.073
Ischemic cardiopathy, n (%)	2 (10.5)	11 (3.9)	0.228
CRP, mg/dL median [IQR]	0.3 [0.1-0.5]	0.4 [0.3-0.8]	0.343
ESR, mm/h median [IQR]	17.0 [15.0-22.3]	13.0 [7.0-29.5]	0.206
Data at last visit (11.8±8.9 years of follow-up)			
IMID duration, years mean±SD	11.8±8.9	14.3±10.3	0.288
# Use of other cardiotoxic drugs, n (%)	2 (10.5)	11 (4.0)	0.723
HCQ cumulative dose, g mean±SD	813.2±206.0	996.3±266.9	0.527

(beta blockers, calcium channel blockers, tricyclic drugs, other AVB inducers)

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POS1371 BIOLOGICAL THERAPY IN REFRACTORY NEUROBEHÇET'S DISEASE. MULTICENTER STUDY OF 42 PATIENTS

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Background: Neuro-Behçet's disease (NBD) is a severe complication of Behçet's disease (BD). Despite well-established therapies with glucocorticoids and conventional immunosuppressants (cIS), a significant proportion of patients are refractory.

Objectives: To assess efficacy and safety of biologic therapy (BT) in NBD refractory to glucocorticoids and at least one cIS.

Methods: Open-label multicenter study of refractory NBD from 23 different referral Spanish Hospitals. Main outcome was neurological response. Secondly, analytical efficacy was measured by Erythrocyte Sedimentation Rate (ESR), C-Reactive Protein (CRP) and Hemoglobin (Hb) at baseline, 6 months, 1 year and 2 years.

Results: We studied 42 patients (21 women/ 21 men; mean age 40.4±10.8 years). HLA B51 was positive in 15 out of 37 (40.5%) patients tested. Non-neurological manifestations were oral ulcers (n=41, 97.6%), genital ulcers (n=31, 73.8%), skin lesions (n=28, 66.7%), arthralgia (n=27, 64.3%), uveitis (n=21, 50.0%), arthritis (n=9, 21.4%), venous thrombosis (n=9, 21.4%) and arterial thrombosis (n=4, 9.5%). The underlying neurologic manifestation were parenchymal (n=34, 81.0%) and non-parenchymal (n=17, 40.5%) involvement (Table 1). The first BT used was infliximab (n=20), adalimumab (n=13), golimumab (n=3), tocilizumab (n=3) and etanercept (n=2).

After 58.2±51.4 months since initiation of BT, neurological response was complete (n=27; 64.3%), or partial (n=11, 26.1%) (Figure 1). Only 4 (9.5%) patients did not respond. After 6 months of BT, ESR improved from 31.5±25.6 to 15.3±11.9 mm/h ($p=0.005$), CRP from 1.4 [0.2-12.8] to 0.3[0.1-3] mg/dL ($p=0.002$) and Hb from 13.1±1.6 to 13.8±1.3 g/dL ($p=0.005$).