doses of IVIG 2g/kg was given; infection treated with antibiotics and regular dressing. After resolution of infection 6 doses of cyclophosphamide as per EUVAS protocol and Rituximab 2 gm was given along with the first dose of Cyclophosphamide.

**Results:** At 48 weeks of follow up, he continues to be in sustained clinical remission without steroids. He has received additional 500 mg of rituximab at 28 weeks. His lung nodules and vasculitic ulcers of leg healed over 34 weeks. He has developed saddle nose deformity for which reconstruction is planned.

**Conclusion:** Steroid free remission in GPA may be possible without Avacopan.

**REFERENCES:**

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**AB1520**

**EFFECTIVE TREATMENT OF TOCILIZUMAB IN PATIENTS WITH REFRACTORY ADULT-ONSET STILL’S DISEASE**

T. Cheng1, Z. Chen2, J. Tan1, Y. Jiang2, Z. Liao2. 1Third Affiliated Hospital of Sun Yat-sen University, Rheumatology and Immunology Department, Guangzhou, China; 2Third Affiliated Hospital of Sun Yat-sen University, Rheumatology and Immunology, Guangzhou, China

**Background:** Pro-inflammatory cytokines such as interleukin 6 (IL-6) are involved in the pathogenesis of adult-onset Still’s disease (AOSD). Anti-IL-6 agents such as tocilizumab have been tried to treat AOSD successfully.

**Objectives:** To access the efficacy of tocilizumab in the treatment of AOSD patient refractory to or with initial treatment.

**Methods:** We reviewed three cases with refractory AOSD treated with tocilizumab. All patients fulfill the Cush criteria for AOSD. All patients performed blood culture, auto-antibodies test and bone marrow test to exclude infectious diseases, other rheumatic diseases and tumors. All patients received broad-spectrum antibiotics and had no response. All patients received glucocorticoid therapy and at least one kind of anti-cytokine therapies but didn’t have full response. Then the three patients received intravenous tocilizumab treatment of 8mg/kg every 2 weeks or 4 weeks.

**Results:**
- The first patient, a 21-year-old woman, performed positron emission tomography (PET-CT) and lymphoglandula pathology in addition to routine tests. She received high dose methylprednisolone (500mg per day for 3 days and followed by 80mg per day), gamma globulin injection (20g per day for 3 days) and baricitinib 4mg per day for 12 days, but had no response to the treatment. Then she received tocilizumab of 8mg/kg every 2 weeks and stopped baricitinib. And the symptoms and blood tests improved gradually, and the methylprednisolone dose reduced to 16mg per day at the last follow-up.
- The second patient is a 52-year-old man, and performed bone marrow cytology and PET-CT to exclude hematological diseases. He received methylprednisolone 80mg per day, adalimumab and tofacitinib treatment. But the patients still got recurrent fever, high ESR, CRP and serum ferritin. Then he stopped adalimumab and tofacitinib, and received tocilizumab of 8mg/kg every 2 weeks and reduced to 8mg/kg every 4 weeks because of economic factors. The patient did not develop fever and the inflammatory indices such as ESR/CRP gradually decreased to normal range. And methylprednisolone dose reduced to 32mg nowadays.
- The third patient is a 30-year-old woman and has recurrent AOSD for 15 years. She had tried glucocorticoids, methotrexate, iguratimod, baritinib and entanercept successively. Yet she still had recurrent arthritis on hand and knee, and elevated ESR/CRP/serum ferritin. Additionally she suffered femoral head necrosis because of excessive doses of glucocorticoid. The patient received tocilizumab 8mg/kg every 4 weeks, then joint symptoms and inflammatory indicators improved significantly. The methylprednisolone dose was also successfully reduced to 4mg/d.

**Conclusion:** Tocilizumab may be an effective candidate in refractory AOSD despite no response to other treatments.

**Disclosure of Interests:** None declared

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**AB1521**

**IGG4-RD AND SLE: COEXISTENCE IN THE KIDNEYS**

O. Mena Mirands1, C. Chao2, M. Vukelic1. 1Albert Einstein College of Medicine, Rheumatology, Montefiore Medical Center, New York, United States of America; 2Icahn School of Medicine at Mount Sinai, Internal Medicine, New York, United States of America

**Background:**
- The first patient is a 31-year-old woman, presented with severe leg edema, tightness, and skin changes of both lower extremities. She has a long history of SLE.
- Figure 1 showed the main course of disease evolution.

**Conclusion:** IGG4-RD and SLE may coexist in the kidneys.