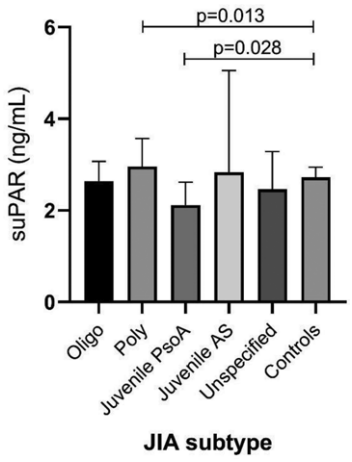

Figure 1.

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POS0767 THE EVALUATION AND IMPORTANCE OF TRANSITION FROM PEDIATRIC TO ADULT RHEUMATOLOGY CARE IN RHEUMATOLOGICAL DISEASES

Keywords: Patient information and education, Descriptive Studies

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Background: The transition from pediatric to adult health care often challenging for young adults with rheumatic diseases. During the transition period, disruptions, diagnostic changes, and treatment differences may occur. The successful transition of the young adult patient to adult care is an important milestone in pediatric rheumatology.
Objectives: In this study, we aimed to examine the diagnosis and treatment changes of transition patients and the characteristics of the transition period in our clinic.
Methods: This was retrospective observational study was carried out in Dokuz Eylul University Pediatric and Adult Rheumatology Department. Patients who followed-up in Pediatric Rheumatology Department transferred to the Adult Rheumatology Department within the last ten years and continued to visit at least once a year were included in this study. If the transition period of the patients was less than three months, it was defined as early transition. Demographic features and educational status, parental divorce, diagnosis changes, and diagnosis-specific treatment changes were recorded.
Results: In total, 962 transitional patients scanned and 210 of them met follow-up criteria. Of the patients, 117 (55.7%) were female, with a median age of 24 (IQR, 21 – 28). Most of patients followed-up juvenile rheumatoid arthritis (JIA) (n=79, 37.6%) and familial Mediterranean fever (FMF) (n=79, 37.6%). Median duration of pediatric rheumatology follow-up was 52 months (IQR, 23 – 87) and 47 (22.%) patients have been treated with biological agent (Table 1). Median transition time was 4 months (1-13 IQR) and the rate of early transition was 46.7%. We found that receiving biological therapy associated with early transition (59.6% vs 40.4%, p=0.040). We also found that Bachelor's degree or higher educational status associated with late transition (40% vs 60%, p=0.025). Rheumatologic diseases were not associated with late transition except FMF, patients with FMF were prone to late transition (32.9% vs 67.1%, p=0.015). Gender and parents' divorce did not associate with transition time (Table 1). The diagnoses of 13% of the participants were changed after they were followed-up in adult rheumatology. The median follow-up period for adult rheumatology was 40 months (15-75 IQR). Biological therapy was started for the first time in 21 patients, the biological therapy of 5 patients was changed, and the biological therapy of 7 patients was discontinued during adult rheumatology follow-up.
Conclusion: We found that most of the patients who were followed-up in pediatric rheumatology in our center did not transition to the adult rheumatology in the same center. Less than half (46.7%) of the patients started to be followed up in adult rheumatology within the first 3 months. Treatment with biological agents was found associated with early transition. Since patients who were treated with biological agent need for a doctor's visit to reach the treatment was considered the main reason for these patients' early transition. We found that Bachelor's degree or higher educational status was associated with late transition. Patients often move to other cities for university may be the reason of the late transition. Transition time did not associate with the rheumatologic diseases except FMF. The reason for the late transition in FMF can be explained by the admission to the hospital frequently with attacks. Transition may be challenging in pediatric rheumatology. The ideal transition to adult rheumatological care should start in the early adolescence period of the patients, planned transition visits may increase the rate of follow-up.

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Table 1. Factors associated with transition duration

	All Participants (n=210)	Early Transition (n=98)	Late Transition (n=112)	P value
Age, years, median (IQR)	24 (21 – 28)	24 (21 – 29)	25 (21 – 28)	0.40
Gender, female, n (%)	117 (55.7)	55 (56.1)	62 (55.4)	0.91
Parents' divorce, n (%)	23 (10.9)	9 (10.7)	14 (13.3)	0.58
Diagnose in Pediatric Rheumatology, n (%)				
JIA	79 (37.6)	42 (53.2)	37 (46.8)	0.015
FMF	79 (37.6)	26 (32.9)	53 (67.1)	
FMF+JIA	6 (2.9)	2 (33.3)	4 (66.3)	
SLE	18 (8.6)	12 (66.7)	6 (33.3)	
Behcet's Disease	9 (4.3)	5 (55.6)	4 (44.4)	
Others	19 (9.0)	8 (42.1)	11 (47.9)	
Duration of Pediatric Rheumology Followed-up, months, median (IQR)	52 (23 – 87)	50 (21 – 85)	55 (24 – 88)	0.48
Duration of transition	4 (1 – 13)	1 (0 – 2)	13 (8 – 28)	<0.001
Education status, n (%)				
Under Bachelor's degree	90 (42.9)	50 (55.6)	40 (44.4)	0.025
Bachelor's degree or higher	120 (47.1)	48 (40)	72 (60)	
Treatment with biological agents at pediatric rheumatology, n (%)	47 (22.4)	28 (59.6)	19 (40.4)	0.040

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POS0768 CHARACTERISTICS OF PATIENTS WITH DIFFICULT-TO-TREAT JUVENILE IDIOPATHIC ARTHRITIS AT ADULTHOOD IN FRANCE

Keywords: bDMARD, Descriptive studies, Prognostic factors

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Background: An effort to unify the variability of juvenile idiopathic arthritis (JIA) phenotypes was initiated in 1994 resulting in the current categories of systemic JIA, oligoarthritis (persistent or extended), rheumatoid factor (RF)-negative polyarthritis, RF-positive polyarthritis, psoriatic JIA, and enthesitis related arthritis. Recently, EULAR has proposed a definition of difficult-to-treat rheumatoid arthritis (D2TRA) and the concept was later extended to spondyloarthritis and psoriatic arthritis.
Objectives: The aim of this study was to describe difficult-to-treat JIA (D2TJIA) at adulthood based on the EULAR definition of D2TRA.
Methods: We stratified consecutive JIA patients treated at Cochin Hospital in Paris into two groups, a D2TJIA group and a non-D2TJIA group. Based on EULAR definition of D2TRA, we defined D2TJIA as JIAs failing at least two targeted therapies, with a different mechanism of action.
Results: In total, we identified 18 D2TJIA patients (mean age 27.4 years, 67% female) and 88 non-D2TJIA patients (mean age 29.1 years, 70% female). Regarding JIA subtypes, we observed significantly more systemic JIA in the D2T group (39% vs 14%, p=0.02). D2TJIA patients were more likely to have erosions on X-rays (82% vs. 55%, p=0.038). Regarding auto-antibodies, positive anti-CCP

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