showed no significant correlation between ESR nor CRP.
Conclusions: According to these results, in long-term follow-up; RA patients receiving, anti-TNF in significant correlation with ESR showed better disease activity.

CRP Evaluation

CRP	Study Group Ort±SD	Control Group Ort±SD	p
Beginning	18,35±20,11	14,11±27,77	0,402
After 12 months	10,79±16,42	10,35±11,79	0,883
CRP level differance between beginning and after 12 months	0,001**	0,272	

Student t test •*Paired Samles t test* *p<0,05 **p<0,01

ESR Evaluation

ESR	Study Group Ort±SD	Control Group Ort±SD	p
Beginning	43,02±19,36	35,17±24,63	0,092
After 12 months	28,50±16,13	24,27±14,99	0,186
CRP level differance between beginning and after 12 months	0,001**	0,001**	

Student t test •*Paired Samles t test* **p<0,01

PS 0693 Rheumatology

Safety of TNF Inhibitor Therapy in Patients Who Have Had a Prior Malignancy

Seung-Hyeon BAE[1], Su Min AHN[1], Do Ho YIM[1], Seokchan HONG[1], Yong-Gil KIM[1], Chang-Keun LEE[1], Bin YOO[1]
Asan Medical Center, Korea[1]

Background: According to the 2012 American College of Rheumatology Recommendations, it is possible to start biologic agent in patients who have been treated for solid tumor. But, there is no evidence in patients with history of a solid cancer treatment within the past 5 years. The purpose of this study was to explore the influence of TNF inhibitor (TNFi) therapy in this subgroup patients.
Methods: The medical records of all patients (n=859) that received TNFi therapy at a single rheumatology clinic between June 2005 and May 2014 were retrospectively reviewed. Among them, data from patients who had a history of solid cancer treatment before TNFi therapy were collected and patient outcomes were evaluated especially for those who have been treated cancer within the last 5 years.
Results: Of 859 patients who underwent TNFi therapy, 22 patients had a history of malignancy before initiating TNFi therapy for ankylosing spondylitis (AS) and rheumatoid arthritis (RA) (Table 1). The median AS, RA disease duration was 8 (3.75-12.25) years and median time to TNFi therapy after prior cancer treatment was 62.5 (21.25-140.25) months. Most common site of prior cancer is stomach (36.4%) and followed by thyroid, colorectum, liver, kidney, and breast. There was no recurrence of previous cancer during 40 (7.0-50.75) months of TNFi therapy. Especially, 10 patients started TNFi therapy before 5 years prior cancer treatment (Table 2). All of our 10 cases were limited in an early stage without distant metastasis. When they have been followed for 36 months, recurrence of cancer was not found.
Conclusions: Our results suggest that starting TNFi therapy in patients with history of solid cancer in locally limited stage is safe even less than 5 years after prior cancer treatment.

PS 0694 Rheumatology

Appearance of Psoriasis after TNF-a Blocker and Use of Ustekinumab or Tocilizumab for Refractory Monoarthritis

Jinyoung MOON[1], Dong Jin GO[1], Jae Hyun LEE[1], Jin Kyun PARK[1], Eun Bong LEE[1], Yeong Wook SONG[1], Jai Il YOUN[2], Eun Young LEE[1]
Seoul National University Hospital, Korea[1], National Medical Center, Korea[2]

Nowadays, tumor necrosis factor-a (TNF-a) blockers are used for the treatment of RA, inflammatory bowel diseases (IBD), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and psoriasis. Paradoxically, there are some reports of appearance of psoriasis after TNF-a blockers. We report a patient who have seronegative mono-rheumatoid arthritis (mono-RA) on knee joint that experienced psoriasis after TNF-a blocker therapy (adalimumab and etanercept). For the patient, oral medication is not available due to intolerance; thus, we tried ustekinumab which is an anti-IL-12/23 monoclonal antibody that has been used to treat psoriasis. After ustekinumab injection, psoriatic skin lesions and joint symptoms were much improved in the patient. But in the following period, joint pain and swelling aggravated and synovial fluid cytokine levels such as IL-6 and IL-17 were elevated. Treatment was changed to tocilizumab, humanized monoclonal antibody against IL-6 receptor. After injection, knee joint swelling rapidly subsided without worsening of psoriatic skin lesion.

PS 0695 Rheumatology

Sarcoid Like Granuloma Developed during Adalimumab Therapy in Ankylosing Spondylitis

Jae-Hoon KIM[1], Jae Kyeom SHIM[2], Young Ho SEO[3], Sung Jae CHOI[4], Young Ho LEE[5], Jong Dae JI[6], Kyung Ho KANG[7], Gwan Gyu SONG[8]
Korea University Guro Hospital, Korea University College of Medicine, Korea[1], Korea University Guro Hospital, Korea University College of Medicine, Korea[2], Korea University Ansan Hospital, Korea University College of Medicine, Korea[3], Korea University Ansan Hospital, Korea University College of Medicine, Korea[4], Korea University Anam Hospital, Korea University College of Medicine, Korea[5], Korea University Anam Hospital, Korea University College of Medicine, Korea[6], Korea University Guro Hospital, Korea University College of Medicine, Korea[7], Korea University Guro Hospital, Korea University College of Medicine, Korea[8]

Introduction: Adalimumab is a full human monoclonal antibody that inhibits tumor necrosis factor-alpha (TNF-a). It has recently been shown to be effective in the treatment of rheumatoid arthritis, ankylosing spondylitis (AS). As the pulmonary complication of TNF-a antagonist, infection, interstitial pneumonitis, sarcoidosis and pulmonary vasculitis has been reported. Sarcoidosis is a rare complication among them. Here, we report a patient who has developed sarcoid like granuloma confirmed by lung biopsy following adalimumab therapy for AS.
Case Description: The patient is a 26-year-old man with a history of ankylosing spondylits evolving over the previous 9 years, who had received treatment with non-steroid anti-inflammatory drugs and sulfasalazin. Adalimumab was injected at a dose of 40 mg twice a month for 9 months with a very positive clinical response. He is admitted due to the patch opacity showed on the right upper and middle lobe at chest radiograph in annual medical checkup. Computed tomography (CT) of the chest revealed various sized multiple nodules on the right upper and middle lobe and lymph node enlargement in both hilum and right paratracheal area. The blood analysis determined ESR 19 mm/hr, CRP 2.16 mg/L with normal renal and hepatic function. The levels of the angiotensin-converting enzyme were 95.7 U/L (normal value 9.0~47.0). The tuberculosis skin test and the interferon gamma releasing assay were negative. Blood cultures and sputum analysis were negative. The microbiological analysis of