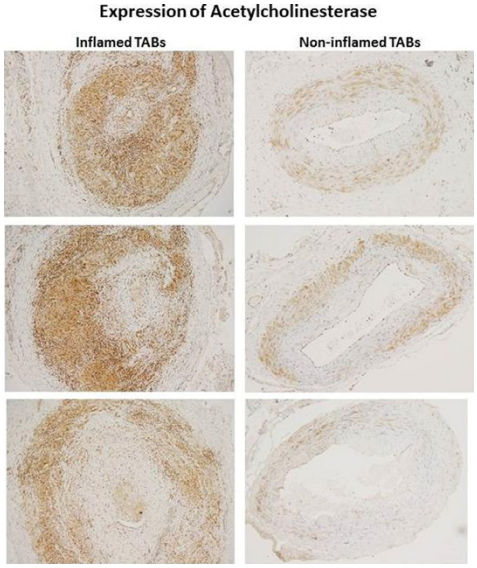
expression were assessed and graded on 0–1-2 scale, blinded to histological and clinical data. Solitary AChE staining of the media was not included in the assessment.

Results: 24 positive and 44 negative TABs, with corresponding clinical positive and negative GCA diagnosis, were included in this study. We found that 10/24 positive TABs showed high AChE expression (grade 2) and 14/24 showed moderate AChE expression (grade 1). No AChE expression was observed outside the media in negative TABs from non-GCA patients (i.e. grade 0). The AChE expression was in 79% agreement with the degree of histological inflammation with a kappa value of 0.58. Prednisolone treatment for up to 7 days did not suppress the AChE expression. Neither the AChE expression, nor the histological inflammation showed correlation to any clinical or biochemical findings.



Conclusions: Our study shows that high to moderate AChE expression was observed in all 24 biopsies from TAB-positive GCA patients and that the AChE expression was in good agreement with the histological inflammation. No non-specific AChE expression was observed outside the media in any of the 44 TABs from TAB-negative non-GCA patients. This indicates that AChE could play a significant role in the inflammatory process in GCA and may be a potential biomarker in inflammatory diseases such as GCA.

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THU0336 GIANT CELL ARTERITIS (GCA) IN OCTOGENARIAN PATIENTS

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Background: GCA is the most common systemic vasculitis in elderly people. It is characterized by granulomatous involvement of the major branches of the aorta with predilection for the temporal arteries. Headache is the most frequent initial complaint, and permanent visual loss the most feared complication.

Objectives: to describe the initial manifestations and outcome of CGA in octogenarian patients, and to investigate if there are some differences compared to younger patients

Methods: demographic, clinical and histological features, treatment and outcome of all patients with biopsy-proven GCA recruited at 11 different Hospitals from Spain (REVAS Study) were analysed. Statistical analysis was performed using SPSS vs. 20

Results: among the 418 patients included in the study, 180 (27.5%) were older than 80 y at disease onset (mean age 83.77±3.1, range 80–92y). Cardiovascular risk factors (hypertension, hypercholesterolemia, diabetes) were more prevalent in octogenarian patients than in younger (73% vs. 50%, p=0.018). Headache was the most frequent initial complaint (78.5%), followed by polymyalgia rheumatica (49.6%), jaw claudication (48.7%) and toxic syndrome (43.5%). A total of 28 (24.35%) patients suffered permanent visual loss, due to anterior ischemic optic ischemic neuropathy (n=26) or central retina vein thrombosis (n=4). When compared with younger patients, neither headache, nor jaw claudication, nor scalp tenderness and polymyalgia, were more common in octogenarian patients. Only fever was less common in patients >80 y at diagnosis than in younger (27.7% vs. 72.3%, p=0.006), and permanent visual loss was most prevalent among octogenarian patients (24.3% vs. 15.7%, OR 1.73, 95CI 1.1–2.9, p=0.04). We found an inverse correlation between fever and permanent visual loss (p=0.001). Blindness was significantly correlated with jaw claudication (p=0.006) and amaurosis fugax (p=0.001). We did not found any significant correlation between blindness and vascular risk factors. Regarding to LAB, ESR was higher in octogenarian patients (p=0.006) as well as thrombocytosis >400.000 platelets/mm (p=0.026). No differences were found related to anaemia prevalence. Inflammatory infiltrate with lumen occlusion and giant cells were significantly more prevalent in temporal artery biopsies from patients with permanent bilateral visual loss (p=0.007 and p=0.01, respectively). No differences were found related to treatment. All patients received oral prednisone at tapering dosage, 85.9% calcium and vitamin D supplementation, and 60% bifosfonates. We did not found differences related to treatment-side effects (osteoporotic fracture, diabetes, infections) between octogenarian patients and the younger.

Conclusions: octogenarian patients with GCA have an increased risk of developing permanent visual compared to younger patients. The presence of jaw claudication and amaurosis fugax must prompt to initiate corticosteroid treatment quickly. No differences were found related to treatment side effects in octogenarian patients.

Disclosure of Interest: None declared

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THU0337 CLASSIFICATION OF ANTINEUTROPHILIC CYTOPLASMIC ANTIBODY-ASSOCIATED VASCULITIS AND CLINICAL IMPACT AND OUTCOME

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Background: Antineutrophilic cytoplasmic antibody (ANCA)-associated vasculitis (AAV) have overlapping manifestations. Classifications based on clinical criteria or ANCA specificity have emerged to individualize homogenized group of patients in terms of clinical forms and outcomes.

Objectives: The aim of our study was to retrospectively re-evaluate the clinical impact and outcome of our monocentric AAV patients' cohort, according to classifications based on clinical criteria and/or ANCA specificity.

Methods: A retrospective monocentric study carried out in Caen university hospital led to identify proteinase-3 (PR3) or myeloperoxidase (MPO)-ANCA AAV patients (via an ELISA technique), respectively from March 1997 to June 2016, and from September 2011 to June 2016. Patients with eosinophilic granulomatosis with polyangiitis were excluded. AAV were classified between granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA), and limited or severe forms according to respectively European Medicines Agency vasculitis algorithm and WGET group. Categorical variables were reported as percentages and compared using Chi^2 or Fisher's tests according to expected frequencies. Continuous variables were expressed as means and analyzed using Student's t-test. Associations between survival, or relapse free survival, and AAV classifications were evaluated by the log-rank test. A p-value <0.05 was considered to be statistically significant.

Results: A total of 150 GPA/MPA were included.

Table 1

	anti-MPO GPA (n=20)	anti-PR3 GPA (n=74)	anti-MPO MPA (n=43)	anti-PR3 MPA MPA (n=13)
Male %	35	54	67	54
Renal involvement %	75	61	88	92
Ear-nose-throat involvement %	65	77	12	0
Lung involvement %	70	80	70	31
Skin involvement %	25	30	21	38
Neurological involvement %	45	24	23	31
Rheumatologic involvement %	55	62	37	54
Limited vasculitis, %	40	23	12	23
Relapse %	50	50	21	8
Death %	0	23	19	31
Initial BVAS, median ± SD	20±7.2	18.5±7.4	17±5.1	15±7.5
Age at diagnosis (years), median ± SD	66.5±11	60±17	62±13	70±21
Follow-up (months), median ± SD	49±47	55±65	50±37	33±108

As expected, ear-nose throat involvement were significantly higher in PR3-ANCA vs MPO-ANCA, and GPA vs MPA (p<0.001). Survival was significantly higher in