been shown to contribute to lupus pathogenesis. It has been suggested that LDGs have a pathogenic role in ANCA associated vasculitis (AAV) based on the data of gene expression signature in AAV and the ability of excessive neutrophil extracellular traps (NETs) formation by LDGs in AAV. However, more detailed analysis of LDG in AAV patients has not been reported.

Objectives: In this study we investigated the characteristics of LDG in AAV patients using flow cytometry and proteomics approach and examined the correlations with disease activity.

Methods: We examined the presence of LDGs in peripheral blood of 10 AAV patients before treatment and followed them for 4 months with immunosuppressive therapy. Normal-density granulocytes (NDGs) were isolated by dextran sedimentation and PBMCs were isolated by Ficoll gradient. LDGs were assessed using cell surface expression of CD14 and CD15 by flow cytometry and isolated by magnetic bead procedure from PBMCs. We performed comparative proteomic analysis among LDGs and autologous NDGs and healthy controls (HC)-NDGs.

Results: LDG frequencies were 9.8-fold higher in AAV patients before treatment relative to HC. There were two distinct populations of LDGs showing different cell surface expressions of CD10, CD14, and CD15 in AAV patients. One population of LDGs was mainly CD10 positive and another one was CD10 negative. Although the frequency of CD10 positive-LDG decreased along with decrease of disease activity, the frequency of CD10 negative-LDG increased in 4 months (17.9-fold higher than before treatment). Comparative proteomic analysis revealed these two populations of LDGs were distinct from each other and had common differences from autologous NDGs and HC-NDGs.

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Conclusions: We identified two distinct subsets of LDGs in AAV. It is possible that they play different roles in the pathogenesis of AAV.

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SAT0517

GENDER DIFFERENCES INFLUENCES CLINICAL PRESENTATION AND VASCULAR PATTERN IN PATIENTS WITH TAKAYASU ARTERITIS: AN ITALIAN MONOCENTRIC STUDY

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Background: Takayasu arteritis (TA) is a large-vessel vasculitis affecting aorta and its major branches¹. Vascular inflammation may cause luminal narrowing, occlusion or aneurysms². TA affects more frequently young women, but occurrence in patients >40 years is not rare. Female: male ratio is 9:1³

Objectives: To compare age at disease onset, age at diagnosis and diagnostic delay between male and female Italian TA patients from our cohort. To compare symptoms presentation and vascular involvement

Methods: Data from 10 male and 104 female TA patients (fulfilling ACR criteria) from our tertiary centre were retrospectively collected. Age at diagnosis, age at first symptom onset, diagnostic delay, signs and symptoms subsequently attributed to TA, and arteries involved before the diagnosis were compared. Non-parametric statistical tests were used

Results: In male patients mean age at diagnosis was 33.5±14.64 years and mean age at onset was 25.8±13.01 years. In female patients mean age at diagnosis was 36.26±12.6 years and mean age at onset was 31±13.1 years. The differences not being statistically significant. The highest percentage of male patients disease onset was <18 years (40%), in female patients it was between 18–40 years (61.5%). Mean diagnostic delay was 92.9±80.78 months in male and 63.03

±85.63 in female patients (p=0.050). Features at disease onset are summarised in table 1. Frequency of limbs claudication was not significantly different in the two groups (50% vs 56.7%), 10% of male patients had upper limbs claudication, compared to 43.3% of female patients, p=0.047. Arterial hypertension was more frequent in male patients (70% vs 35.6%, p=0.044). Acute coronary syndrome was more frequent in male patients (30% vs 5.8%, p=0.031). Frequency of cardiovascular risk was not significantly different in the two groups (40% vs 32.7%). Coronary angiography was more frequently performed in male patients (30% vs 2.9%, p=0.009). At disease onset, compared to female patients, male patients coronary (30% vs 6.7%, p=0.042), iliac (50% vs 15.4%, p=0.018) and femoral arteries (40% vs 6.6%, p=0.008) were more frequently involved. In female patients subclavian arteries were more frequently involved (72% vs 40%, p=0.066).

Signs/symptoms	N°male patients (%)	N°female patients (%)	P-value
Constitutional symptoms	5 (50)	61 (58.7)	0.740
Arthralgias	3 (30)	28 (26.9)	1
Carotidynia	1 (10)	25 (24.0)	0.451
Syncope/vertigo	2 (20)	22 (21.2)	1
Neurological signs	1 (10)	8 (7.7)	0.576
Overall limbs claudication	5 (50)	59 (56.7)	0.746
Upper limbs claudication	1 (10)	45 (43.3)	0.047*
Lower limbs claudication	5 (50)	25 (24.0)	0.125
Arterial hypertension	7 (70)	37 (35.6)	0.044*
Discrepancy in BP	1 (10)	29 (27.9)	0.287
Reduced/absent pulses	3 (30)	46 (44.2)	0.511
Vascular bruits	4 (40)	32 (30.8)	0.723
Angina abdominis	0 (0)	16 (15.4)	0.353
Chest pain	3 (30)	9 (8.7)	0.071
Acute coronary syndrome	3 (30)	6 (5.8)	0.031*
Serositis	0 (0)	7 (6.7)	1

Conclusions: Male patients with TA have more frequent involvement of the coronary arteries and of the iliac and femoral arteries. As a consequence, they suffer more frequently acute coronary syndrome and lower limbs claudication. Besides, they have more frequently arterial hypertension

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SAT0518

THE ROLE OF LEFLUNOMIDE IN THE TREATMENT OF GIANT CELL ARTERITIS

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Background: Glucocorticoids (GC) have been the mainstay treatment in giant cell arteritis (GCA) for decades. Recently tocilizumab and abatacept have been proven to be effective alternatives to glucocorticoids. However, not all GCA patients are eligible for a biologics.

Objectives: We aimed to evaluate the role of leflunomide (LEF) as a steroid sparing agent in GCA.

Methods: This prospective observational study included newly diagnosed GCA patients followed at least 48 weeks at a single secondary/tertiary rheumatology centre.

Patients were treated with GC in line with the EULAR recommendations.¹ In short, patients with uncomplicated GCA initially received oral methylprednisolone (MP) 32–48 mg qd, while those with ischaemic complications or large vessel disease first received MP 250 mg on 3 consecutive days intravenously, followed by oral MP. MP tapering was started 2–4 weeks after treatment initiation slowly to 4 mg qd which was continued for at least 6 months. At week 12, LEF 10 mg qd was recommended as an add-on therapy to those GCA patients without contraindications for it. The final decision to add LEF was patient dependent. Follow-up visits with predetermined clinical and laboratory tests were performed 4, 12, 24, 48, 96 and 144 weeks after diagnosis. In patients who relapsed during the MP tapering unscheduled visits were arranged and treatment was adjusted (GC dose was