increased and LEF 10 mg or LEF dose increase to 20 mg or alternative steroid sparing agent in case of LEF ineffectiveness recommended). The number of relapses and a cumulative GC dose during follow-up were recorded.

Results: Between July 2014 and December 2016 we identified 76 (65.8% female; median age 73.7 [66.1–78.8] years) new GCA cases with a follow-up of at least 48 weeks (median age 75 [71–104] weeks). 30.7% patients (39/76) received LEF at W12 (“LEF group”), the others continued with GC only. During the follow-up 22 patients relapsed, 4 in “LEF group” (13.5%) and 18 (39.1%) in “GC only” group. The difference was statistically significant (p=0.02; NNT 3.9 (95%CI 2.2–17.4)). Furthermore, 17/30 GCA cases (56.7%) in “LEF” group managed to stop GC at W48 (with 1 relapse (5.9%) shortly afterwards), whereas none in GC only group. Patients tolerated LEF relatively well. Adverse events (AEs) were usually mild. 8/17 (47%) patients with ANCA-positive vasculitis may develop interstitial lung disease (ILD).

Background: We conducted a retrospective 10 year chart review at the Mayo Clinic for ANCA-Associated Vasculitis: Comparison with Idiopathic Pulmonary Fibrosis and Interstitial Pneumonia with Autoimmune Features.

Methods: We conducted a retrospective 10 year chart review at the Mayo Clinic Florida, including patients with confirmed diagnoses of both AAV and ILD done by expert rheumatology and pulmonology clinical evaluations. Clinical characteristics and prognosis are not well known in these patients. The largest report to date is from East Asia describing microscopic polyangiitis (MPA) as the most common association with ILD.

Objectives: To describe the clinical manifestations and response to therapy of patients with AAV and ILD compared with patients with idiopathic pulmonary fibrosis (IPF) and interstitial pneumonia with autoimmune features (IPAF), which were confirmed by applying the IPF diagnostic criteria based on the most recent ATS guidelines and IPAF criteria defined by Fischer and colleagues, respectively.

Results: We identified 24 ANCA-ILD patients. 14 patients had MPA, 12 patients had granulomatosis with polyangitis (EGPA). 54% were female and mean age was 70. In 14 patients (58.3%) had granulomatosis with polyangitis (GPA), and 2 patients had eosinophilic granulomatosis with polyangiitis (ECPA). 42% were female and mean age was 59. In half of the ANCA-ILD patients, vasculitis presented prior to ILD, mainly MPA, 36% of patients presented with ILD first, most of them with GPA. The rest presented with ILD and vasculitis at the same time. Usual interstitial pneumonia (UIP) was the most common radiographic pattern. Honeycombing was more common in MPA compared to GPA patients. Ground glass opacity was present in 5 (63%) of GPA and in 5 (36%) of MPA patients. Most GPA patients had positive anti-MPO antibody and p-ANCA. Only one GPA patient had positive anti-MPO antibody and two were p-ANCA positive. The majority of the GPA patients were positive for anti-proteinase-3 antibody and c-ANCA. The mainstay of treatment was: prednisolone (n=21), azathioprine (n=7), mycophenolate mofetil (n=3), cyclophosphamide (n=1), rituximab (n=1), and cyclosporine (n=1). In 4 patients (16.7%) treatment was: cyclophosphamide (n=3), cyclosporine (n=1), rituximab (n=1), and cyclophosphamide (n=1). However, there are controversial results regarding its efficacy in the treatment of extraocular manifestations of BD.

Conclusions: We found in our prospective observational study in GCA a steroid sparing action and a rather good tolerability of LEF.

Disclosure of Interest: None declared