Abstract SAT0531 – Table 1. Prednisone doses and acute phase reactants at GCA flare

	TCZ-QW N=100	TCZ-Q2W N=49	PBO+26 N=50	PBO+52 N=51
Patients who experienced flare, n (%) ^a	23 (23)	13 (27)	34 (68)	25 (49)
Median (min–max) prednisone dose at flare, mg	7.0 (0.0–30.0)	2.0 (0.0–310.0)	6.5 (0.0–55.0)	10.0 (2.0–40.0) ^e
Patients who experienced first flare while on prednisone dose, mg/day, n (%) ^a				
0	5 (5.0)	4 (8.0)	9 (18.0)	0
1–5	5 (5.0)	4 (8.0)	7 (14.0)	5 (9.8)
>5–10	5 (5.0)	3 (6.0)	4 (8.0)	10 (19.6)
>10–20	5 (5.0)	1 (2.0)	9 (18.0)	8 (15.7)
>20–30	3 (3.0)	0	2 (4.0)	0
>30–40	0	0	2 (4.0)	1 (2.0)
>40–60	0	0	1 (2.0)	0
>60	0	1 (2.0)	0	0
Median (min–max) CRP, ^b mg/L	0.4 (0.2–93.2)	1.0 (0.2–18.1)	23.1 (1.4–119.0)	17.3 (0.2–122.0)
Flare patients with elevated CRP, ^b n (%) ^c	1 (4)	2 (15)	22 (65)	17 (68)
Median (min–max) ESR, ^d mm/h	5.0 (0.0–80.0)	5.0 (1.0–43.0)	51.0 (8.0–140.0)	39.0 (4.0–138.0)
Flare patients with elevated ESR, ^d n (%) ^c	1 (4)	3 (23)	27 (79)	14 (56)

^aPercentage based on N. ^bNormal ≤10 mg/L. ^cPercentage based on n who experienced flare. ^dNormal <30 mm/h. ^en=24

Conclusions: Acute phase reactants are not reliable correlates of disease flare in TCZ-treated patients, but approximately one-third of all PBO +prednisone patients also had normal acute phase reactants at the time of disease flare. Median prednisone dose at the time of disease flare for TCZ-treated patients was numerically lower than that of patients treated with PBO +prednisone. One-third of all disease flares in GACTA occurred while the patient was receiving >10 mg/day prednisone.

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SAT0532 TREATMENT WITH METHOTREXATE AND RISK OF ISCHAEMIC RELAPSES IN PATIENTS WITH GIANT CELL ARTERITIS IN CLINICAL PRACTICE

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Background: Clinical trials show the efficacy of Methotrexate (MTX) in giant cell arteritis (GCA). It is necessary to corroborate these results in real life.

Objectives: To assess the incidence and the risk of ischaemic relapses in GCA patients treated with and without Methotrexate (MTX) in clinical practice.

Methods: Retrospective longitudinal observational study. **Subjects:** patients treated at the Rheumatology Service of the Hospital Clínico San Carlos with the diagnosis of GCA. They were included from the date of diagnosis (January 1991 to September 2013) and followed-up until lost of follow up or Sept-2014. **Main outcome:** relapses by ischemic event (RIE): Presence of mandibular claudication, visual manifestations (blurred vision, diplopia, transient or permanent loss of vision), cerebrovascular accident, ischaemic heart disease or claudication of limbs, after having achieved an objective improvement, associated with an

increase in the erythrocyte sedimentation rate (ESR) and the need to increase corticosteroids (at least 10 mg over the previous dose). **Independent variable:** exposure to MTX over time. **Secondary variables:** sociodemographic, clinical and treatment. **Statistical analysis:** RIE rates were assessed by survival techniques, expressing the incidence per 100 patients*year with their 95% confidence interval [CI]. The influence of MTX on the RIE was analysed by multivariate Cox regression models. Results were expressed as Hazard ratios (HR) with their respective CI.

Results: 168 patients were included with a follow-up of 675.59 patients*year. 80.36% were women (mean age: 76.77±7 years). The most prevalent comorbidities were arterial hypertension (64%), dyslipidemia (34%), cardiovascular pathology (30%) and polymyalgia rheumatica (13.77%). The most common clinical symptom at diagnosis was headache (87.43%), systemic involvement (55%) and polymyalgia rheumatica (49.70%). The ESR was 78±30.85 mmHg and Hb of 12.06±1.58 mg/dL. 46.39% had a positive biopsy. 64% were on MTX (mean dose: 10 mg) at any time during the follow-up, from those 68% started MTX in the first 4 weeks after diagnosis. The mean dose of corticosteroids was 50.72 ±15.46 mg. There were 21 relapses by ischaemic events (12.5%), with an incidence of 3.1 [2.02–4.77]. The median time to first RIE was 0.4 [p25–75: 0.4–5.1] years. The incidence of RIE in patients exposed to MTX was 1.92 [0.8–4.62], whereas in those without MTX was 3.84 [2.36–6.28]. The incidence of RIE in women was 3.44 [2.17–5.46] and in men was 1.97 [0.6–6]. In the multivariate analysis after adjusting for age, sex, disease activity and calendar time, exposure to MTX had less risk of relapse by ischaemic event compared to those without MTX (HR 0.3 [0.096–0.99]; p=0.048).

Conclusions: The frequency of RIE was 12.5%. The incidence of RIE was 3% patients-year. With the results observed in this study, the use of MTX seems to decrease the risk of relapses by ischaemic event.

Disclosure of Interest: None declared

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SAT0533 POLVAS – RETROSPECTIVE REGISTRY OF POLISH PATIENTS WITH ANCA-ASSOCIATED VASCULITIDES

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Background: Vasculitides are a heterogeneous group of rare diseases with unknown etiology and the clinical spectrum ranging from life-threatening systemic disease to minor isolated skin changes. Present nomenclature and definitions of systemic vasculitides have been proposed in 2012 at the International Chapel Hill Consensus Conference.¹ Antineutrophil cytoplasmic antibody (ANCA)-associated vasculitides (AAV) belong to the small to medium-size vessel systemic diseases comprising granulomatosis with polyangiitis (GPA), microscopic polyangiitis (MPA) and eosinophilic granulomatosis with polyangiitis (EGPA).

Objectives: We decided to retrospectively analyse a large cohort of Polish AAV patients coming from referral centres – members of the Scientific Consortium of the Polish Vasculitis Registry (POLVAS).^{2,3}

Methods: We conducted a systematic multicenter retrospective study of adult patients diagnosed with AAV between Jan 1990 and Dec 2016. Patients were enrolled to the study by 9 referral centres (14 clinical wards: – rheumatology – 10, nephrology – 2, metabolic diseases – 1, clinical immunology – 1) from 7 Voivodships populated by 22.3 mln inhabitants (58.2% of the Polish population). Patient data have been collected according to the uniform protocol in the POLVAS registry.

Results: Distribution of AAV in the Polish population resembles that of north European cohorts.⁴ In POLVAS registry 417 (66.7%) patients were diagnosed with GPA, 106 (17.0%) with MPA and 102 (16.3%) with EGPA. Male-to-female ratios were almost 1:1 for GPA (210/207) and MPA (54/52), but EGPA was twice more frequent among women (34/68). Clinical manifestations and organ involvement were analysed both by clinical phenotype (GPA, MPA, EGPA) and ANCA specificity (anti-PR3+, and anti-MPO+). Analysis by ANCA specificity showed no apparent difference as compared to phenotype analysis. Clinical manifestations

of different AAV in the Polish population seems very similar to other European countries.

	GPA	MPA	EGPA	
Number	417	106	102	
Male/female	210/207	54/52	34/68	*, \$
Mean (median) age (yrs.); range	48,9 (51,4) ¹³⁻⁸⁰	61,5 (63,7) ¹⁹⁻⁸⁵	44,6 (44,5) ⁹⁻⁸⁵	*, \$
Organ involvement				
General n (%)	355 ^(85,1)	83 ^(78,3)	87 ^(85,3)	NS
Skin n (%)	140 ^(33,6)	24 ^(22,6)	51 ⁽⁵⁰⁾	*, \$
Eye n (%)	114 ^(27,3)	4 ^(3,8)	6 ^(5,9)	*, \$
ENT n (%)	315 ^(75,5)	18 ^(17,0)	82 ^(80,4)	*, \$
Respiratory n (%)	315 ^(75,5)	60 ^(56,6)	100 ^(98,0)	*, \$
Heart n (%)	55 ^(13,2)	11 ^(10,4)	43 ^(42,2)	*, \$
GI n (%)	46 ^(11,0)	12 ^(11,3)	25 ^(24,5)	*, \$
Renal n (%)	252 ^(60,4)	101 ^(95,3)	25 ^(24,5)	*, \$
Urinary n (%)	8 ^(1,9)	3 ^(2,8)	0	NS
CNS n (%)	45 ^(10,8)	2 ^(1,9)	8 ^(7,8)	*, \$
Neurological n (%)	75 ^(18,0)	20 ^(18,9)	50 ^(49,0)	*, \$

p<0,05; # – GPA vs MPA, * – GPA vs EGPA, \$ – MPA vs EGPA

Conclusions: This is the first multicenter retrospective study of the Polish patients suffering from with AAV. Demographic characteristics and disease manifestations of AAV patients in POLVAS registry follow the same pattern as those from other European countries.⁴

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SAT0534 ANNUAL INCIDENCE OF GIANT CELL ARTERITIS IN URBAN AND RURAL AREAS IN WESTERN NORWAY 1972–2012

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Background: Giant cell arteritis (GCA) is the most common vasculitis in adults. The etiology is not fully understood, and environmental factors which may influence the incidence are poorly investigated.

Objectives: To determine the potential influence of rural or urban residence on the incidence of GCA during a 41 year period.

Methods: Hospital-based retrospective cohort study including patients diagnosed with GCA in Bergen Health Area during 1972–2012. Patients were identified through computerised hospital records using the International Classification of Diseases (ICD)-coding system. Clinical information was extracted by review of the patients' medical journals. The patients' residential address was obtained from the population register in Norway. Municipalities were classified as urban (code 1 and 2) or rural (code 3 thru 6) using the Statistics Norway 2017 classification of centrality. The background population data was obtained from Statistics Norway (www.ssb.no). Wilcoxon signed-rank test was used for statistical comparison.

Results: The inclusion process have been published previously.¹ For the computing of incidence 743 patients were included. Among these there were 536 (72%) females (mean age 73.4 years, SD 8) and 207 (28%) males (mean age 72.6, SD 9). 493 patients (66%) had a positive temporal artery biopsy. 484 patients (65%) had a residential address in a municipality classified as urban and 259 (35%) in a rural municipality. The number of inhabitants (aged ≥50 years) in urban areas (i.e. city of Bergen) was 60 910 in 1972 and 81 972 in 2012. The corresponding number of inhabitants in rural areas was 30 320 and 51 401. The overall annual cumulative incidence of GCA was 16.7 (95% CI 15.5–18.0) per 100 000 persons ≥50 years. The mean annual incidence for urban municipalities was 17.1 (95% CI 15.9–18.4) per 100 000 ≥50 years. The corresponding incidence for rural areas was 16.1 (95% CI 14.9–17.3), p=0.46. With regards to biopsy-proven GCA, the overall annual incidence was 11.2 (95% CI 10.2–12.3). In urban and rural areas, the incidence of biopsy-proven GCA was 11.7 (95% CI 10.6–12.7) and 10.4 (95% CI 9.4–11.4) respectively, p=0.10. There were large fluctuations in annual incidence in both urban and rural areas (figure 1).

Conclusions: Annual cumulative incidence of GCA was slightly higher in urban than in rural areas in our study, but the difference was not statistically significant. This is in contrast to a previous study, which found GCA more prevalent in urban than in rural populations.² Further studies are required to determine whether there is a true difference in incidence of GCA in urban versus rural populations, and whether or not exposures to environmental factors may be involved in GCA pathogenesis.

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SAT0535 EULAR 2018 CORE SET OF DATA TO BE COLLECTED IN GIANT CELL ARTERITIS REGISTRIES AND DATABASES VIEWPOINTS FROM A EULAR TASK FORCE

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Background: Giant cell arteritis (GCA) represents the most common form of primary vasculitis and can be associated with severe and potentially life-threatening complications. Due to its low prevalence, systematically collected data on course and outcome of this disease are scarce.