there is a normal distribution, or as median [25–75 IQR] when there is an usual one.

**Results:** 27 patients were analysed (14 W/13 M). At the beginning of the IGIV the average age was 57.8±15.98 and the vasculitis average development was 1.29±0.68. The vasculitis ANCA subtypes were: a) granulomatosis with polyangiitis (n=14; 51.8%), b) microscopic polyangiitis (n=9; 33.3%), c) eosinophilic granulomatosis with polyangiitis (n=2; 7.4%), d) pulmonary-renal syndrome with ANCA positive (n=1; 3.7%) and e) indeterminate vasculitis ANCA positive (n=1, 3.7%).

Previously to the treatment with IGIV, apart from steroids, they also received: cyclophosphamide (n=12, 44.4%), metotrexate (n=6, 22.2%), Infliximab (n=5, 18.5%), rituximab (n=4, 14.8%), azatioprine (n=3, 11.1%), mycophenolate (n=3, 11.1%) and plasmapheresis (n=1; 3.7%).

Refraction less (n=18) and susceptible of infection (n=9) were the reasons for the application of IGIV. The IGIV guideline was 0.4 g/kg/day for 5 consecutive days. After a follow-up of 89±68 four months we observed clinical and analytical improvement, as well as in the activity indexes (TABLE). The majority of the side effects were lower and IGIV was suspended in just one patient due to severe effects of congestive heart disease.

Conclusions: IGIV seems to be an effective and secure therapy in the treatment of vasculitis ANCA.

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**SAT0542**

**INCIDENCE OF LARGE VESSEL GCA IN NORTHERN ITALY DURING A 12-YEAR PERIOD (2005–2016)**

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**Background:** There are no studies regarding the incidence of large vessel GCA (LV GCA).

**Objectives:** To investigate the incidence of LVGCA in the Reggio Emilia Area from 2005 through to 2016.

**Methods:** All patients with incident large vessel GCA diagnosed between 1 January 2005 and 31 December 2016 and living in the Reggio Emilia area, were identified by capture and re-capture checking of computerised discharge diagnosis codes (ICD10) and using outpatients databases from rheumatology, internal medicine, surgery, pathology, imaging departments of Reggio Emilia Hospital as well as by examining the Reggio Emilia district database for rare diseases. To be included in the study, patients must satisfy the following 2 criteria: Age at disease onset >50 years; evidence of large-vessel vasculitis by angiography, MRA, CTA, PET/CT and/or ultrasonography. We included in the study also patients associating biopsy proven GCA with evidence of LVV. We also evaluated the incidence of biopsy proven GCA without LV in same time period.

**Results:** There were 93 incident cases of LV GCA (66 women, 71%) during the 12 year study period; Mean ±SD age at diagnosis was 72±9 years. Incidence per 1 00 000 persons aged ≥50 years was 3.78 (95% confidence interval 3.01, 4.55). In particular incidence was 1.60 in LV GCA with biopsy proven GCA and 2.18 in LV GCA not biopsy proven GCA (pts biopsy negative and pts in which the biopsy had not been performed). Incidence was significantly higher in women (4.89 [95% CI 3.69, 6.09] than in men (2.50 [95% CI 1.56, 3.45]) (p<0.0006). The highest incidence in women was observed in the 70–79 years age group (7.72 [95% CI 4.99,11.56] while in men the peak of incidence was in the 80–89 age group (4.23 [95% CI 2.50,6.46]). A progressive increase in total incidence rates was observed during the 4 three years periods from 3.13 (2005–2007) to 4.85 (2014–2016). The incidence per 1 00 000 persons aged ≥50 years of GCA biopsy proven without LV during the 12 year study period was 4.48 [95% CI 2.22,9.45].

**Conclusions:** The incidence of LV GCA in the Reggio Emilia area 100.000/aged ≥50 was 3.78 and it was lower than that of patients with biopsy proven GCA without LV; the incidence of LV GCA was significantly higher in women and increased during the study period.

**REFERENCE:**


**Disclosure of Interest:** None declared