A patients with giant cell arteritis with extensive extra and intracranial large vessel involvement effectively treated with cyclophosphamide followed by mycopheno-
late mofetil will be presented. Diagnosis and management of ischaemic complica-
tions in giant cell arteritis will be discussed.

Disclosure of Interest: None declared

SP0049 HEAD GAMES WITH GCA AND GCS
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Case 1: This is a 65 y/o woman with osteoporosis, depression and recently diag-
nosed polymyalgia rheumatica characterised by shoulder and hip girdle pain and
stiffness with elevated inflammatory markers. She developed recurrent symptoms
and new-onset jaw and tongue claudication in the setting of a prednisone taper.
She was found to have a bulging right temporal artery and biopsy confirmed giant
cell arteritis. She was placed on prednisone 60 mg daily with resolution of her
symptoms, but developed worsening symptoms of depression and anxiety with
insomnia on high dose prednisone. She subsequently attempted suicide by inten-
tional medication overdose and carbon monoxide poisoning. She was admitted to
the psychiatry ward and additionally found to have a varicella zoster skin rash.
Upon resolution of the zoster infection she was started on tocilizumab by subcuta-
neous injection weekly and prednisone was successfully tapered over 4.5 months
without recurrence of symptoms.

Case 2: This is a 63 y/o woman with ITP on monthly rituximab and chronic predni-
sone 10 mg daily, hypertension, hyperlipidemia and osteoarthritis who developed
worsening shoulder and neck pain for two months with more recent onset of scalp
tenderness and left-sided vision changes for two weeks. He was found to have left
optic neuropathy, elevated inflammatory markers, and an MRI demonstrating
enhancement of the left temporal lobe. Left temporal artery biopsy was normal.
He was given pulse dose intravenous methylprednisolone for suspected giant cell
arteritis and transitioned to high dose oral prednisone with improvement in muscu-
loskeletal symptoms, inflammatory markers and stabilisation of his vision. He sub-
sequently developed insomnia, hyperactivity and talkativeness and was
diagnosed with steroid-induced mania, which improved with antipsychotics and
benzodiazepines as per the psychiatry service. He was discharged home and
after three days developed new vision loss of the right eye on prednisone 60 mg
daily. On exam, he was found to have progressive visual field loss of the left eye
and new inferior visual field loss of the right eye with disc oedema of the right optic
nerve. Right temporal artery biopsy was negative. He was again given pulse dose
intravenous methylprednisolone followed by oral methylprednisolone and ulti-
mately received tocilizumab intravenously prior to discharge.

Disclosure of Interest: None declared

THURSDAY, 14 JUNE 2018
Do we still need biopsies to diagnose Sjögren’s and autoimmune myostis?

SP0050 OPPORTUNITIES AND CHALLENGES OF IMAGING IN PRIMARY SJÖGREN’S
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Sjögren’s syndrome (SS) is a chronic autoimmune inflammatory disorder of exo-
crine glands. Its diagnosis relies solely on a combination of clinical and laboratory
findings. However, recent developments have shown that imaging techniques
may have additional value in detecting salivary glands abnormalities in pSS. In
general, sialography is considered to be the most reliable of the imaging methods.
Salivary gland scintigraphy is very sensitive and especially useful in early stages
of the disease. Nevertheless, both imaging techniques are used by only minority
of rheumatologists for diagnosis of pSS because of the invasive character of sial-
ography and the low specificity of scintigraphy. MRI has shown a good sensitivity
and specificity to detect structural abnormalities in pSS but few centres have
access to the specific know-how. A recent development is the increased interest
in ultrasonography (US) as a tool to assess major salivary glands. Ultrasonogra-
phy of the salivary glands (SGUS) appears to be an inexpensive commonly avail-
able noninvasive technique that does not cause complications and inconvenience
to the patient, although the data are somewhat conflicting. Although, the recent
but preliminary American classification criteria for Sjögren syndrome do not
include salivary gland such imaging technique ‘this procedure has clearly demon-
strated high impact on classification of Sjögren patients’ and demonstrated good
diagnostic properties. ‘A systematic literature review’ has shown a paucity of data
regarding the metric properties of ultrasound, making interpretation and

THURSDAY, 14 JUNE 2018
Clinical challenges in giant cell arteritis in 2018

SP0048 A CASE OF PULSELESS STROKE
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Giant cell arteritis (GCA) is the most common form of vasculitis in individuals aged
50 years and over. GCA typically affects large and medium-sized arteries, with a
predilection for the extracranial branches of the internal carotid artery. Patients with GCA
usually present with symptoms and signs that are directly related to the artery that
is affected, with or without constitutional manifestations. The most dreaded com-
pliation of GCA is visual loss, which affects about one in six patients and is typi-
ically caused by arteritis of the ophthalmic branches of the internal carotid artery.
Before the advent of glucocorticoid treatment, the prevalence of visual complica-
tions was high. Increasing awareness by physicians of the symptoms of GCA and
advances in diagnostic techniques over the past twenty years have also contrib-
uted to a substantial decline in the frequency of permanent visual loss. Ischaemic
brain lesions are less common than visual lesions, and mostly result from vasculi-
tis of the extradural vertebral or carotid arteries. In the case of both the eye and
the brain, ischaemic damage is thought to result from arterial stenosis or occlusion
that occurs secondary to the inflammatory process.