Sexual health is rarely addressed by health professionals (HP), and it is as a rule not spontaneously reported by patients. HPs may feel awkward to intrude into the intimate sphere of a patient, and patients may feel ashamed of revealing their sexual dysfunction.

A first step to improve the physician-patient communication in this area is to include sexuality in the curriculum of health professionals teaching how to address and evaluate sexual function. Assessment of sexual function by validated instruments includes both frequency of intercourse as well as sexual desire, arousal, orgasm, and sexual satisfaction. In women vaginal lubrication and in men erectile function and ejaculation are part of the evaluation. Assessment of disease activity and comorbidities helps to detect physical components of sexual dysfunction.

Barriers regarding communication on sexual activity should be identified and overcome. Assessment of sexual function may be assigned to a specially trained nurse, an occupational therapist or a psychologist of the interdisciplinary team. Referral to specialists in urology, gynaecology or sexual medicine may also help patients to get a better sex life. A major point for restoring sexual and reproductive health in patients of both genders is to achieve optimal disease control.

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SP0047 **CHALLENGES IN THE MANAGEMENT OF DIFFERENT RHEUMATOLOGIC DISORDERS DURING PREGNANCY: LESSONS FROM THE REGISTRIES**

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Registers have considerably expanded our knowledge in many fields of rheumatology. In particular, the Biologics Registers contribute to an enormous increase in knowledge on the "real world" safety of the rapidly growing treatment options. Family planning in the case of RD is a particular challenge in the physician-patient relationship and requires an optimal strategy. The impact of pregnancy on the underlying disease or the impact of maternal disease on the outcome of pregnancy is not yet fully understood. In addition there is still a high unmet need of data on drug safety as women with wish to have children or pregnant women are excluded from registration studies for ethical reasons. Therefore, systematic and prospective observation in daily care is the best possibility to collect data on this subject. Data options range from clinical-based cohort studies (e.g. the PROMISSE study), prospective pregnancy exposure studies (e.g. the MotherToBaby studies) to national birth registries. Recently, pregnancy registers in women with RD have been established in several European countries. Together with other studies, these registers will hopefully add to improved expertise in the future

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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 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 complication of GCA is visual loss, which affects about one in six patients and is typically caused by arteritis of the ophthalmic branches of the internal carotid artery. Before the advent of glucocorticoid treatment, the prevalence of visual complications was high. Increasing awareness by physicians of the symptoms of GCA and advances in diagnostic techniques over the past twenty years have also contributed to a substantial decline in the frequency of permanent visual loss. Ischaemic brain lesions are less common than visual lesions, and mostly result from vasculitis 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.

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

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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 diagnosed 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 intentional 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 subcutaneous injection weekly and prednisone was successfully tapered over 4.5 months without recurrence of symptoms.

Case 2: This is a 63 y/o man with ITP on monthly rituximab and chronic prednisone 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 artery. 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 musculoskeletal symptoms, inflammatory markers and stabilisation of his vision. He subsequently 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 ultimately received tocilizumab intravenously prior to discharge.

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Do we still need biopsies to diagnose Sjögren's and autoimmune myostitis?

SP0050 **OPPORTUNITIES AND CHALLENGES OF IMAGING IN PRIMARY SJÖGREN'S**

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Sjogren's syndrome (SS) is a chronic autoimmune inflammatory disorder of exocrine 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 sialography 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. Ultrasonography of the salivary glands (SGUS) appears to be an inexpensive commonly available 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[1] this procedure has clearly demonstrated high impact on classification of Sjögren patients[2–5] and demonstrated good diagnostic properties.[5] A systematic literature review[6] has shown a paucity of data regarding the metric properties of ultrasound, making interpretation and