the elderly is Giant Cell Arteritis (GCA) and one of the unusual manifestations of GCA includes non-productive cough that can occur in about 10% of patients. It is speculated that vasculitis in the area of cough receptors results in this manifestation. There have been only anecdotes about the association of GCA with ILD and it is unknown whether ILD is truly prevalent in patients with GCA.

Objectives: Here we systematically reviewed chest images of patients with GCA and investigated the prevalence of CT scan abnormality consistent with ILD among patients with GCA.

Methods: Single centre retrospective chart review was conducted at St. Luke's International Hospital in Tokyo. The charts of patients with the diagnosis of GCA who were seen from March 2004 till August 2017 were extracted. The clinical data were obtained. Pulmonary images were reviewed by one of the authors, who is a pulmonologist and characteristics of the pulmonary lesions based on computed tomography (CT) of the lung were recorded.

Results: Forty-six patients had a diagnosis of Giant Cell Arteritis. Thirty-nine of them had a chest CT scan. The mean age of the patients was 69 ± 17 years and 27 patients (58%) were female. Ten patients (26%) had abnormality in the CT scan. The abnormality included linear infiltrates beneath the posterior aspect of the pleura in the lung bases ($n=9$), ground glass opacities ($n=3$), honeycombing ($n=3$), and reticulonodular infiltrates ($n=2$). Two patients received prednisolone for ILD, ILD of whom were stable. No patients died during the median follow up of 14.5 months.

Conclusions: Chest CT abnormality consistent with mild ILD was prevalent among patients with GCA. The prognosis of these patients appears to be favourable and these patients responded to prednisolone.

Disclosure of Interest: None declared

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AB0666

CLINICAL AND SEROLOGICAL OUTCOMES OF PATIENTS WITH GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB OR ABACEPT AS STEROID-SPARING AGENTS

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Background: Giant cell arteritis (GCA) is a common form of systemic vasculitis. The current mainstay of GCA management is glucocorticoid (GC) therapy. Recently, at least 2 biological therapies [tocilizumab (TCZ) and abatacept (ABA)] have been proven to be effective in the management of CGA in randomised controlled trials. Nevertheless, their use as steroid sparing agents might need further investigation.

Objectives: We aimed to investigate the steroid-sparing effect of biological therapies, namely TCZ and ABA, in a cohort of GCA patients when compared to standard GC treatment.

Methods: We retrospectively collected data from GCA patients who attended the S.G. Bosco Hospital, Turin, Italy, who were treated with TCZ, both intravenous (IV) and subcutaneous (SC), and/or ABA SC (8 mg/kg/month, 162 mg/week, and 125 mg/week respectively). These therapies were prescribed as first line agents or as second line when patients were refractory/intolerant/contraindicated to standard immunosuppressive therapies. Complete response to the treatment was defined as a clinical and serological remission after 12 months of therapy; partial response was defined as clinical or serological remission after 12 months of therapy.

Results: This retrospective study included 33 GCA patients [mean age 74 (range 85–57), females 63%, mean follow-up from GCA diagnosis 44.4 ± 33.5 months]. Table 1 resumes the characteristics of the GCA patients included in the study. Twenty-eight patients out of 33 (85%) received one biologic agent. Five patients (15%) needed a therapeutic switch (one patient from TCZ to ABA, and 4 patients from ABA to TCZ). Patients were treated as follow: 9 with TCZ IV, 11 with TCZ SC, and 18 with ABA.

Among the TCZ IV group, all patients experienced a response (57% complete response, and 43% partial response). Among the TCZ SC group, 83% experienced a response (67% complete response, and 16% partial response). Among the ABA group, 86% experienced a response (36% complete response and 50% partial response). After 12 months of therapy, 100% of patients in TCZ groups, both IV and SC, and 64.2% of ABA group were treated with low doses of oral prednisone (≤ 7.5 mg/day) as maintenance. We noticed a significant reduction of inflammatory parameters [C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)] after 12 months of therapy with TCZ [TCZ IV group: mean baseline CRP (mg/dl) 1.9 ± 2.3 , mean CRP after 12 months of therapy 0.3 ± 0.2 ; mean baseline ESR (mm/h) 58.1 ± 25.6 , mean ESR after 12 months 9.5 ± 4.2 ; TCZ SC group: mean baseline CRP 4.5 ± 3.8 , mean CRP after 12 months 0.2 ± 0.2 ; mean baseline ESR 51.9 ± 27 , mean ESR after 12 months 6.5 ± 6]. When compared to standard GC regimen,¹ in patients treated with TCZ, both IV and SC, we estimated a median steroid-sparing effect quantifiable in 30 mg/daily in the first month and an overall steroid-sparing effect of 15 mg/daily when assessed in 12 months.

Abstract AB0666 – Table 1. Characteristics of GCA patients included in the study

	Total number of patients (33)	%
Demographic characteristics		
Female/Male	21/12	
Age (years) (mean, SD)	73.6 $\pm$ 8.7	
Clinical characteristics at the onset of GCA		
Fever (n)	12	36.4
Fatigue (n)	18	54.5
Headache (n)	28	84.8
Scalp tenderness (n)	8	24.2
Jaw claudication (n)	15	45.4
Vision loss (n)	16	48.5
PMR (n)	11	33.3
Diagnosis		
Biopsy proven	27/32	84.4
PET positivity	12/29	41.4
Eco-color-doppler positivity	30/31	97
GC therapy		
Previous methylprednisolone pulses (n)	7	21.2
Oral prednisone (n)	33	100
Dose of oral prednisone (mg/day) (mean, SD)	49.7 $\pm$ 15.1	
Previous immunosuppressive therapies		
Methotrexate (n)	11	33.3
Mean dose (mg/week) (mean, SD)	15.6 $\pm$ 1.7	
Mycophenolate (n)	6	18.1
Mean dose (g/day) (mean, SD)	2.2 $\pm$ 0.4	

Conclusions: This retrospective study confirms the efficacy of biological therapies in the management of CGA. Besides, in our experience TCZ allowed a significant reduction of GCs use, especially in the first month of therapy, when compared to standard GCs-based regimens.

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AB0667

PREGNANCY OUTCOMES IN A TERTIARY TAKAYASU ARTERITIS CARE CENTRE

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Background: Fertility and pregnancy are concerning issues in women of child-bearing age with Takayasu arteritis (TA). Available data on the management and expected events in TA during pregnancy are sparse and inconsistent among study populations^{2,3}. Conflicting reports exist on both favourable pregnancy outcomes as well as increased fetal or maternal complications^{1,4}.

Objectives: To assess the obstetric and maternal outcomes in a tertiary centre TA cohort.

Methods: 15 female patients fulfilling the American College of Rheumatology 1990 criteria for the classification of TA were included in this retrospective study. Data regarding number of pregnancies, disease characteristics and pregnancy related events were gathered from medical records. Disease extent was classified according to Numano classification criteria for TA: type I (4 patients, 26.66%), type III (4 patients, 26.66%), type V (3 patients, 20%), type IV (2 patients, 13.33%), type IIa (1 patient, 6.66%), type IIb (1 patient, 6.66%). The prevalence of obstetric and maternal complications was evaluated in women before or after TA diagnosis. 6 patients were further excluded due to the paucity of information concerning pregnancy outcomes.

Results: A total of 15 pregnancies were identified in 9 patients, with 9 (60%) occurring before TA diagnosis – group 1, and 6 (40%) occurring concomitant with or after TA diagnosis – group 2. In the first group the extent of arterial involvement was mostly consistent with type I TA (6 pregnancies, 66.66%). No fetal or maternal complications were observed in this group. Type III TA was most commonly encountered (4 pregnancies, 66.66%) in group 2. Only one patient from the second group had more than 1 pregnancy after TA diagnosis. Active disease (National Institutes of Health/NIH score >1) was reported in 2 (33.33%) pregnancies in the second group. Cardiovascular events occurred exclusively during 2 (33.33%) pregnancies exhibiting active disease. One patient suffered severe aortic regurgitation and gestational hypertension during pregnancy, while the second patient experienced worsening of preexisting hypertension. These required steroid dose increase and addition of antihypertensive drugs. There were no obstetric events in group 2.

Conclusions: Most TA pregnancies are uneventful, bearing favourable fetomaternal outcomes. However, pregnant TA patients with active disease, have higher risk of developing maternal complications, especially cardiovascular events. In this setting, close monitoring and disease remission should be maintained during pregnancy.

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AB0668 TREATMENT OF THROMBOTIC EVENTS IN BEHÇET DISEASE: A SYSTEMATIC LITERATURE REVIEW

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Background: Behçet's disease (BD) is a systemic disease which etiopathogenesis is largely unknown. It is characterised by a wide variety of clinical manifestations. Venous disorder is a serious manifestation being potentially life-threatening. There is little evidence on the management of the venous complications in BD.

Objectives: To perform a systematic literature review on the treatment used in venous thrombotic events in BD.

Methods: The objective was reformulated according to the PICO approach. Several synonyms for the main components (i.e. Behçet, thrombosis, treatment) were used. Search limits were applied for humans. The literature search was performed in Medline and Embase from databases inception to 1st November 2017. Only articles in English and Latin languages were retained. We excluded abstracts, reviews and letters. From the selected studies, data about the venous involvement and treatments were retired using a predefined data collection form.

Abstract AB0668 – Table 1

Treatment	Nº articles (%)
Anticoagulant	22 (78.6)
Antiplatelet	9 (33.3)
Corticosteroids	22 (78.6)
Immunosuppressive	25 (89.3)
Cyclophosphamide	16 (57.1)
Azathioprine	16 (57.1)
Cyclosporine A	5 (17.9)
Mycophenolate mofetil	2 (7.1)
Interferon alpha	2 (7.1)
Methorexate	4 (14.3)
Hydroxychloroquine	1 (3.6)
Anti-TNF alpha	4 (14.3)
Colchicine	11 (39.3)
Thalidomide	1 (3.6)
Dapsone	1 (3.6)
Fibrinolytic	3 (10.7)
Surgery	7 (25.9)

Results: The literature search resulted in 1552 articles, of which 632 were captured in Medline and 920 in Embase. Figure 1 shows the study flow-chart for article selection. The main reasons for article exclusion after full-text review were the lack venous involvement and the lack of explanation of venous involvement treatment. 28 articles reporting 1904 patients were included in qualitative analysis. The mean (range; SD) duration time between the disease onset and the vascular onset was evaluated in 15 articles and was 4.9 (1.2–9.3; 2.7) years. Superficial thrombosis was evaluated in 6 (21.4%) articles, profound thrombosis in 19 (67.9%) articles, cerebral in 7 (25%), inferior or superior cava vein in 15 (53.6%) and Budd-Chiari syndrome in 8 (28.6%) articles. Table 1 shows the treatments described in the selected articles. Treatment response was evaluated in 20 (71.4%) articles; in 7 of these treatments response was evaluated in a subjective way. In total, 52 (2.7%) deaths were reported in relation to BD. In 319 (16.7%) patients, partial efficacy or recurrence of thrombosis was reported. Considering the heterogeneity of the reported data and the variability in the measures of treatment response, predictors of mortality risk cannot be analysed. However, in the reviewed articles, a higher mortality rate was observed in patients with hepatic involvement due to Budd-Chiari syndrome. We have also observed a higher risk for the development of venous thrombosis in patients with patergia phenomenon and male sex. Two studies suggested that immunosuppressive treatment

concomitant with anticoagulant treatment is associated with a lower risk of thrombosis relapse compared with anticoagulant treatment alone.

Abstract AB0668 – Figure 1

Conclusions: There is a great variability in the treatment of venous thrombosis related to Behçet's disease. Budd-Chiari syndrome seems to be related to a worse prognosis of the disease.

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AB0669 MAINTENANCE TREATMENT WITH ADALIMUMAB IN REFRACTORY UVEITIS DUE TO BEHÇET'S DISEASE: OPTIMISED VS NON-OPTIMISED GROUP

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Background: Uveitis is the most common ocular manifestation in Behçet's Disease (BD), which can cause irreversible blindness.¹⁻²

Objectives: To assess efficacy, safety and cost-effectiveness of adalimumab (ADA) therapy optimisation in a series of patients with uveitis due to BD.

Methods: Multicenter study of 74 ADA-treated patients with BD uveitis refractory to conventional immunosuppressants. Following remission, optimisation was performed by increasing the ADA dosing interval. Comparison between optimised and non-optimised group was performed.

Results: Ocular remission was achieved in 65 (86.6%) patients after a median ADA duration of 6³⁻¹² months. ADA was optimised in 23 cases. In the remaining 42 ADA was maintained at 40 mg/sc/2 weeks. No baseline differences were found at ADA onset between the optimised and non-optimised groups. Ocular outcomes were similar after a mean $\pm$ S.D. follow-up of 34.7 $\pm$ 13.3 and 26 $\pm$ 21.3 months in the both groups (table 1). Adverse effects were seen in non-optimised group (lymphoma, pneumonia, local reaction and bacteremia). Mean ADA treatment costs were lower in the optimised vs non-optimised group (6101.25 €/patient/year vs 12339.48).