confirmed flexor tenosynovitis (white arrows) and intercarpal synovitis (yellow arrow) in keeping with RS3PE syndrome.

Abstract AB0671 – Figure 1

Conclusions: On whole body PET/CT, RS3PE syndrome is associated with a distinctive volar pattern of abnormal ^{18}F -FDG uptake at the wrist and hand, which correlates with flexor tenosynovitis and intercarpal synovitis as previously described on MRI.

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AB0672 18F-FDG WHOLE BODY PET/CT AS A DIAGNOSTIC TEST FOR POLYMYALGIA RHEUMATICA IN PATIENTS WITH NORMAL INFLAMMATORY MARKERS

C.E. Owen^{1,2}, E. Martin¹, A.M. Poon^{2,3}, J.L. Leung^{1,2}, D.F. Liew^{1,2}, S.T. Lee^{2,3,4}, A. M. Scott^{2,3,4}, R.R. Buchanan^{1,2}. ¹Rheumatology, Austin Health, Heidelberg VIC; ²Medicine, University of Melbourne, Parkville VIC; ³Molecular Imaging and Therapy, Austin Health; ⁴Olivia Newton-John Cancer Research Institute, Heidelberg VIC, Australia

Background: Despite abnormal C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) being required in the 2012 EULAR/ACR classification criteria, 7%–20% of polymyalgia rheumatica (PMR) patients possess normal inflammatory markers at diagnosis.¹ A characteristic pattern of ^{18}F -fluorodeoxyglucose (^{18}F -FDG) uptake is seen on whole body positron emission tomography/computed tomography (PET/CT) in PMR, hence this imaging modality may be a useful diagnostic test in this clinical scenario.

Objectives: To report the utility of whole body PET/CT for diagnosing PMR in patients with normal inflammatory markers and compare the clinical and radiologic characteristics of this subgroup with patients from the Melbourne Predictors of Relapse in PMR (MPR-PMR) study.

Methods: Patients presenting with clinical features of PMR according to the 2012 EULAR/ACR classification criteria but normal CRP and ESR underwent ^{18}F -FDG PET/CT as part of their diagnostic work-up. A whole body scan from skull vertex to feet (including dedicated hand views) was performed using the Phillips T/F machine prior to prednisolone commencement. Qualitative and semi-quantitative (standardised uptake value maximum [SUV_{max}]) scoring of abnormal ^{18}F -FDG uptake was undertaken. Newly diagnosed and untreated PMR patients who underwent the same ^{18}F -FDG PET/CT protocol as part of the MPR-PMR study were used as the comparator group. Statistical analysis was conducted using Stata 13.1 (StataCorp, College Station, TX, USA).

Results: Three patients with normal inflammatory markers (Median CRP 1 [0.9–2], median ESR 6^{1–7}) underwent ^{18}F -FDG PET/CT. Mean age was 60.15±7.55

years, two patients (66.67%) were male and all were Caucasian. Shoulder and hip pain was present in all cases, but only one patient reported peripheral joint involvement. Median early morning stiffness (EMS) was 30 min.^{15–60} On whole body PET/CT, characteristic ^{18}F -FDG uptake was visualised in each patient at the shoulder capsule, trochanteric bursae and adjacent to the ischial tuberosities, with hip capsule involvement similarly present in 2/3. When compared with 35 patients from the MPR-PMR study, there were no statistically significant differences in the clinical characteristics nor the distribution or intensity of abnormal ^{18}F -FDG uptake between the two populations.

Conclusions: In patients with suggestive clinical features but normal inflammatory markers, whole body PET/CT may be utilised to confirm a diagnosis of PMR.

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AB0673 ANCA-ASSOCIATED VASCULITIS AND INFECTIONS: RETROSPECTIVE ANALYSIS IN A REFERRAL CENTRE

J. Álvarez Troncoso, Z. Iannaccone, E. Álvaro Valiente, C. Busca Arenzana, L. Ramos Ruperto, G. Daroca Bengoa, J. Vasquez Manau, F. Arnalich Fernández, J.J. Ríos Blanco. *Internal Medicine, Hospital Universitario La Paz, Madrid, Spain*

Background: The antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis (AAV) are rare multisystem autoimmune diseases of unknown cause, characterised by inflammatory cell infiltration causing necrosis of blood vessels. The AAV comprise granulomatosis with polyangiitis (GPA), microscopic polyangiitis (MPA) and eosinophilic granulomatosis with polyangiitis (EGPA). The AAV are autoimmune diseases with potentially severe systemic involvement that require prolonged immunosuppressive therapy. Infection is a frequent complication in AAV and is associated with increased morbidity and mortality.

Objectives: The aim of this study was to define epidemiology, ANCA patterns, treatments, infections and outcomes of a series of 39 patients with AAV.

Methods: We retrospectively analysed 39 patients diagnosed with AAV between 1995 and 2017 from the Internal Medicine Department of a Spanish referral centre.

Results: A total of 39 patients were reviewed. 23 female (58.9%). Mean age at diagnosis was 55.6 years. Median time delay to diagnosis was 7.6 weeks. Median follow-up was 91.3 months. Most frequent AAV was MPA with 18 patients (46.2%), followed by GPA with 11 (28.2%) and EGPA with 10 (25.6%). 6 patients (15.4%) had a concomitant autoimmune disease: Systemic sclerosis,² Antiphospholipid syndrome,² Lupus¹ and Sjögren.¹ Only 2 patients (5.1%) had previous infection with hepatitis C virus. Regarding the treatments, all patients received corticoids (bolus 24 patients, 61.5%), 29 (74.4%) cyclophosphamide, 10 (25.6%) rituximab, 19 (48.7%) azathioprine, 4 (10.3%) mycophenolate and 1 (2.6%) methotrexate. 16 patients presented post-treatment lymphopenia, 5 pancytopenia, and 15 hypogammaglobulinemia. 21 patients (53.8%) presented any infection after the diagnosis. The most frequent were bacterial infections (15 patients), presenting 9 patients with sepsis criteria (7 due to gram-negative organisms). 9 opportunistic infections were described: 3 infections by cytomegalovirus, 5 by tuberculosis and 1 by *Mycobacterium avium*. There were no cases of *Pneumocystis jirovecii* despite the fact that only 16 patients (41%) performed primary prophylaxis. The factors associated with increased risk of infections were: lymphopenia, pancytopenia and increased BVAS ($p<0.05$). 6 patients had died at the time of the study (3 associated with infections, 2 with neoplasms and 1 directly with AAV). The Charlson index performed at the time of the study was the best predictor of mortality ($p<0.01$).

Conclusions: Infections were a frequent complication in patients with AAV and one of the main causes of mortality. Risk factors were lymphopenia, pancytopenia and increased BVAS. Bacterial infections were the most frequent but opportunistic infections must be taken into account.

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