graft occlusion or endoleak occurred in two out of 3 aneurysms patients who underwent endovascular stent placements. As for concomitant medical conditions, one patient complicated with hepatitis B infection, and three complicated with latent tuberculosis infection and received anti-tuberculosis prophylaxis. Prior to TCZ therapy, all patients experienced disease progression despite high-dose glucocorticosteroid in combination with multiple immunosuppressants. All patients received TCZ, 8 mg/kg iv every 4 weeks for a median of 7 (range 3 to 15) doses, and baseline medium-to-low dose corticosteroid and immunosuppressants. After a median follow-up of 16 months (range 4 to 29), all patients achieved both clinical and serological improvements. Radiologic improvement of artery stenosis was demonstrated in one patient. The condition of one patient with endoleak after the stent placement remained stable without surgical intervention. No newly-onset arterial lesions or venous thrombosis were observed. The median ESR (18 vs 7 mm/h, $p<0.05$) and hsCRP level (30.6 vs 2.0 mg/L, $p<0.05$) were also significantly decreased. Furthermore, corticosteroids dose was tapered from 27.1 ± 6.3 mg to 8.9 ± 1.2 mg ($p<0.05$), and immunosuppressants were tapered in number and dosage in 3 (42.9%) and 3 patients (42.9%), respectively. No serious adverse event or TB reactivation was observed.

Conclusions: TCZ, in combination with corticosteroids and immunosuppressants, was effective and well tolerated in severe/refractory vascular BD, with a favourable steroid- and immunosuppressant-sparing effect.

Disclosure of Interest: None declared

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AB0712

ELIGIBILITY OF PATIENTS WITH GIANT CELL ARTERITIS FOR ENTRY INTO A PROSPECTIVE RANDOMISED CONTROLLED TRIAL: A SINGLE-CENTRE EXPERIENCE

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Background: The interest in pharmaceutical trials in giant cell arteritis (GCA) is increasing. Trial recruitment may be more challenging in GCA than in other rheumatic diseases because of a higher proportion of elderly patients who are additionally faced with a new diagnosis when being considered for trial participation.

Objectives: To analyse the eligibility of newly diagnosed and flaring GCA patients in one centre for randomization in the SIRRESTA trial (ClinicalTrials.gov Identifier, NCT02531633; sirukumab versus placebo), to list reasons for non-randomization, and to compare eligible with non-eligible patients.

Methods: All patients with newly diagnosed or relapsing GCA considered for trial participation between August 2016 until trial termination in October 2017 were included. The trial was prematurely terminated by the sponsor based on the decision to discontinue development of sirukumab in autoimmune diseases. Analysis of variance, two-sided Fisher's exact and Pearson's chi-squared tests were applied for calculating statistical significance.

Abstract AB0712 – Table 1. Comparison of eligible and non-eligible GCA patients for trial participation

	Total	Eligible for trial	Not eligible for trial	Significance
N	95	12 (13%)	83 (87%)	
Age (SD)	71.1 (8.3) years	65.3 (8.0) years	71.8 (8.5) years	0.008*
Females	61%	75%	59%	0.356
New diagnosis	81%	58%	84%	0.047*
Cranial GCA only	46%	58%	45%	0.537
Cranial and extracranial GCA	35%	25%	36%	0.533
Extracranial GCA only	19%	17%	19%	1.0
Ischaemic events	14%	0%	16%	0.208
Headache	59%	58%	59%	1.0
Jaw claudication	34%	33%	34%	1.0
PMR	62%	83%	59%	0.125
ESR (SD)	71 (33) mm/h	85 (31) mm/h	69 (34) mm/h	0.125
CRP (SD)	90 (69) mg/l	121 (83) mg/l	85 (65) mg/l	0.095

* $p<0.05$, significant; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; GCA, giant cell arteritis; PMR, polymyalgia rheumatica; SD, standard deviation

Results: Ninety-five patients were pre-screened. Fifteen of these patients were screened and only 12 of the 95 (13%) pre-screened GCA patients were eligible for randomization based on inclusion and exclusion criteria. The other 83 patients were not eligible for one or more of the following reasons: Concomitant diseases (42%) including second autoimmune disease (11%), malignancy (6%), history of diverticulitis (5%), hepatopathy (2%), renal insufficiency (1%) frailty (6%) and dementia (2%), ischaemic disease (2%); 1 myocardial infarction and 1 severe tongue necrosis), abnormal or inconclusive tests for tuberculosis (5%) and

hepatitis (1%); failure to meet inclusion criteria (41%), including symptoms (12%), histology/imaging (1%), exceedance of maximum glucocorticoid dose (7%), too low ESR and CRP (10%), too long treatment duration (11%); declined consent (29%), before (11%) and after receiving the consent form (18%); too long distance to study centre (5%).

Patients eligible for the trial were younger. They had no ischaemic complications (see table 1). A higher proportion of relapsing GCA patients were included. This subgroup of a larger trial represents only data from one centre. It may not be representative for the findings in other centres or the whole study.

Conclusions: Many newly diagnosed or relapsing GCA patients were not eligible for a trial due to concomitant diseases, failing inclusion criteria or declined consent. Eligible patients were younger; and more had relapsing disease.

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AB0713

INTERFERON-ALPHA FOR THE MANAGEMENT OF LOWER EXTREMITY DEEP VEIN THROMBOSIS IN BEHCET'S SYNDROME: A CASE SERIES

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Background: Lower extremity deep vein thrombosis (LEDVT) is a disabling complication of Behçet's syndrome (BS). Relapses are frequent and cause permanent disability due to post-thrombotic syndrome.¹ The management of LEDVT in Behçet's syndrome (BS) constitutes mainly of azathioprine (AZA) and corticosteroids (CS) as first-line agents.² Interferon- α (IFN) has been used with good results in the management of eye involvement of BS. However data regarding its efficacy for vascular involvement has been scarce.³

Objectives: We aimed to evaluate the efficacy and safety of IFN for LEDVT in BS.

Methods: All BS pts who had a first episode of acute LEDVT since March 2010 are being prospectively followed with a standard protocol in our dedicated BS centre. Acute LEDVT is confirmed by Doppler ultrasonography (DUS) at initial diagnosis and serial DUS assessment is performed and also repeated in case of clinical suspicion of relapse. Our standard treatment strategy consists of AZA and CSs as first-line treatment in pts with LEDVT. IFN has been used in pts who were refractory or intolerant to this regimen, or who had co-existing eye involvement. Our endpoints for assessing efficacy of IFN have been recanalisation of the index thrombus and prevention of relapses. Presence of recanalisation of thrombosed vein and extension of thrombosis have been assessed at each visit. Recanalisation has been assessed in the transverse plane and defined as the ratio of the vein area at maximum compressibility to the non-compressed vein area. Good recanalisation was defined as a ratio of at least 50%. Adverse events during IFN use were recorded.

Results: 33 pts with LEDVT (26 M/7 F) were prospectively followed for a mean of 40.7 ± 13.4 mo. Among these IFN was started in 18/33. In 2 pts IFN was started at the first episode of LEDVT due to co-existing uveitis. Seven pts were treated with IFN due to LEDVT relapses under AZA. In the remaining 9 pts, the reasons for switching from AZA to IFN were adverse events with AZA ($n=2$), relapse of superficial thrombophlebitis ($n=4$), leg ulcers due to severe post-thrombotic syndrome ($n=2$) and eye involvement ($n=1$). Among 17 pts treated with IFN mainly for vascular involvement during a mean follow-up of 29 ± 20 mo, 3 pts already had good recanalisation when starting IFN. In the remaining 14 pts, 13 (93%) had good recanalisation under IFN. Two pts (11%) experienced relapses. One of the 2 pts who had a relapse had had poor recanalisation despite IFN. In contrast, among the 29 pts treated with AZA, only 13 (45%) had good recanalisation and 13 (45%) pts experienced relapses. Nine of the 13 pts who had relapses under AZA had poor recanalisation. Overall we observed 23 LEDVT relapses in 15 pts. Relapse rates were 29%, 37% and 45% at 6, 12 and 24 months respectively. The only adverse event with interferon-alpha causing drug withdrawal was thyroiditis in 1 patient.

Conclusions: Relapse rate for LEDVT in BS is high despite AZA treatment. IFN seems to be a promising agent for preventing LEDVT relapses and achieving good recanalisation, an important predictor of relapse. The small number of pts and the lack of a parallel control group are the limitations of this prospective study.

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