Methods: Cohort study of IgAV patients (ICD-9-CM 287.0/ICD-10-AM D69.0) using non-exposed age-matched controls (1:3), where pregnancy-related events and outcomes (see table 1 for ICD codes) were extracted from state-wide hospital morbidity data for period 1980 to 2015. Results are presented as odds ratios (95% CI) versus controls.

Results: Pregnancy-related contacts (n=1,440) occurred in 49.5% of all female IgAV patients (n=347) and in 37% of all female controls (n=914). IgAV patients were younger at first pregnancy (23.7 vs 26.4 years, $p<0.01$) and had a higher overall mean number of hospital pregnancy contacts than controls (5.4 vs 3.1, $p<0.001$). IgAV patients experienced 168 uncomplicated live births, 93 complicated (including preterm) deliveries and 32 abortive pregnancies. The risk for abortion (OR 1.3, CI: 0.7 to 2.3), complicated delivery (OR 0.9, CI: 0.7 to 1.3) or classification as high-risk pregnancy (OR 0.94, CI: 0.74 to 1.24) was similar for IgAV patients compared to controls, despite a higher risk of hypertensive disorders (OR 4.4 CI2.1–9.1).

Abstract OP0239 – Table 1. Diagnostic codes used for data extraction from health registries

Definition	ICD9 codes	ICD10 codes
Any pregnancy event	630–80, V22–V24, V27, V30–V40	O00–O85, Z33–Z35, Z37–Z39
Normal delivery healthy child	650.1–9	O80.1–9
Complicated delivery	652–670	O81–O85
Abortive outcome	630–640, 656.4	O00–O08.9, Z33.2
High risk pregnancy	V23–V24	O09–O09.9
Hypertension in pregnancy	642–643	O10–O15.9

Conclusions: In this large population-based longitudinal study, the risk for abortion or complicated pregnancies/deliveries was not increased for IgAV patients. The more frequent hospital contacts and increased risk of hypertension during pregnancy in IgAV patients had little impact on pregnancy outcome.

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OP0240 FAVOURABLE LONGTERM OUTCOME IN PATIENTS WITH GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB. REAL LIFE DATA FROM A SWISS CENTRE

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Background: Tocilizumab (TCZ) has been shown to be effective for achieving sustained glucocorticoid (GC)-free remission in patients with giant cell arteritis (GCA) ^{1,2}. However, data on real life patients and longterm follow up is still limited.

Methods: We included all patients with GCA or polymyalgia treated with TCZ iv (8 mg/kg/month) in our division from 1/2013 to 1/2018. Safety and efficacy were analysed retrospectively.

Results: 42 patients were analysed (69% female). Patients with involvement of cranial vessels (n=20) were older than patients without cranial involvement (n=16) (72.8±6.4 vs 63.2±10.3 years, $p=0.05$). Initially, 9 patients had AION, vascular stenosis was detected in 10 and aneurysms in 9 patients.

Initial vascular imaging included MR/CT angiography in 36 and 14 patients, ultrasound in 23 patients and PET CT in 8 patients.

Mean duration of TCZ therapy was 18.2±9.6 months with treatment ongoing in 33 patients. Since 2013, the time between diagnosis and initiation of TCZ as well as the number of immunosuppressants before TCZ decreased. All patients initially received iv methylprednisolone followed by standard oral tapering of prednisone starting with 1 mg/kg/d. PMR patients were started on oral GC. Low dose ASS or oral anticoagulants were used in 83% and statins in 55% of GCA patients.

Before the first RCT of TCZ in GCA was reported³, TCZ was initiated in 25 patients after failure of conventional immunosuppressives after a mean disease duration of 12.7±11.2 months. TCZ was started after failure of one immunosuppressant in 19/25 patients, 6/25 patients failed to at least 2 immunosuppressants. Since 12/2015, 17 patients were started on TCZ with a significantly shorter disease duration

(mean 4.1±5.4 months) ($p=0.0047$). 14/17 patients received TCZ after GC alone, in only 3 patients MTX was used before TCZ.

GC free remission was achieved in 24/33 patients (73%) with ongoing TCZ treatment. GC free and TCZ free remission was achieved in 6 patients only (4/6 PMR, 2/36 patients with GCA). Therefore, a favourable outcome was noted in 30/42 patients (76.2%). In 12 patients, TCZ was stopped in patients with GC free remission. 3/11 patients relapsed after 11, 11 and 3 months and responded to reinitiation of TCZ and GC, all achieving GC free remission again. 3 GCA patients stopped TCZ in GC free remission, but died of vascular complications during follow-up.

Infections during TCZ treatment included 2 patients who developed herpes zoster, one patient with RSV pneumonia and one patient with bronchitis, all occurring within the first 6 months of TCZ treatment and during concomitant GC therapy (9.5%). TCZ was reinitiated in all of these patients without subsequent complications. 3 patients developed ischaemic vascular complications (7.1%) during treatment with TCZ: 1 patient with cerebral infarction and 2 patients developed progressive vascular stenosis.

Conclusions: TCZ resulted in GC free remission in 76% of patients. Unfavourable events were limited to infections and vascular complications. However, sustained remission without TCZ was observed infrequently and was mainly limited to patients with PMR. Our data suggest that patients with GCA benefit from continuous treatment with TCZ.

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OP0241 EFFICACY OF TOCILIZUMAB IN TAKAYASU ARTERITIS: MULTICENTER FRENCH RETROSPECTIVE STUDY OF 46 PATIENTS

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Background:

Objectives: We report the long term outcome of 46 TA patients treated with tocilizumab, describe the factors of response and compare the vascular event free survival to DMARDS.

Methods: retrospective nationwide french study

Results: We observed a decrease in the NIH scale; in C-reactive protein levels and in daily prednisone dose at 3 and 6 months, respectively; $p<0.0001$) under tocilizumab. The overall tocilizumab failure free survival was 81% [95% CI: 0.7 to 0.95], 72% [95% CI: 0.55 to 0.95] and 48% [95% CI: 0.2 to 0.1] at 12, 24 and at 48 months, respectively. The presence of constitutional symptoms at the time of tocilizumab initiation (hazard ratio 5.6 [95% CI: 1.08 to 29], $p=0.041$), C-reactive protein level (hazard ratio 1.16 [95% CI: 1.01 to 1.31] for every 10 mg/L, $p=0.003$) were significantly associated with tocilizumab-failure-free survival. The incidence of vascular complications of TA decreased significantly under tocilizumab compared to DMARDS therapy.

Conclusions: This nationwide study shows that tocilizumab may reduce the incidence of vascular complications in TA.

Disclosure of Interest: None declared

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