was shorter at relapsing patients (44 vs 64 months, $p=0.001$). Smoking rate was higher at male patients but no association was observed with vascular relapses.

Abstract FRI0488 – Table 1. Clinic and demographic features of Behçet's Disease patients

		Female (n=22)	Male (n=102)	p
Mean age at first vascular event		37±12.6	31.5±8.5	0.019
Mean age at BD diagnosis		30.5±9.5	29.1±7.5	0.467
Smoking	Yes	4 (%33.3)	32 (%68.1)	0.018
	No	8 (%66.7)	15 (%31.9)	
Pteryg	Positive	12 (%66.7)	54 (%62.8)	0.99
	Negative	6 (%33.3)	32 (%37.2)	
Number of vascular event/s	1	14 (%63.6)	55 (%54.5)	
	2	6 (%27.3)	39 (%38.5)	
	3 or more	2 (%9.1)	7 (%7)	

Abstract FRI0488 – Table 2. Type and characteristics of vascular involvement

Venous n=134 (%73.2)	Extremities	Arteries n=44 (%23.5)	Pulmoner Trombus	36 (% 81.8)
	Cerebral	16 (% 12)	Aneurysme (2 coronary, 2 pulmoner, 2 aorta)	6 (% 13.6)
	Others (SVC, IVC, renal, retinal)	12 (8.9)	PAT+PAA	2 (% 4.6)

IVC: inferior vena cava, PAA: pulmoner arter aneurysmei, PAT: pulmoner arter trombus, SVC: superior vena cava

Conclusions: Our results show that female BD patients have a vascular event at a later age compared to males, but the course of vascular disease is not influenced with gender. Early termination of immunosuppressive treatments seems to be the most important cause of vascular relapses

Disclosure of Interest: None declared

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FRI0489 UTILITY OF APREMILAST IN REFRACTORY ORAL AND/OR GENITAL ULCERS IN BEHÇET'S DISEASE

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Background: Behçet's disease (BD) is characterised by recurrent oral and/or genital ulcers accompanied by ocular, cutaneous, articular, gastrointestinal, and/or neurologic manifestations. Oral and/or genital aphthous ulcers are often refractory to conventional treatment. Apremilast is an orally-active small molecule which inhibits phosphodiesterase-4 (PDE-4) that modulates some inflammatory pathways.

Objectives: Our aim was to assess the efficacy of apremilast in BD patients with oral and/or genital ulcers refractory to conventional treatment.

Methods: Retrospective national multicenter open-label study on 19 BD patients treated with apremilast at standard dose of 30 mg twice daily. The main outcome was achievement of oral ulcers remission.

Results: We included 19 patients (14 women and 5 men) with a mean age of 43.6 ±14.8 years. Before apremilast, all patients had also received several systemic conventional drugs: oral corticosteroids (n=18), colchicine (n=19), NSAIDs (n=10), methotrexate (n=10), azathioprine (n=10), cyclosporine (n=6), infliximab (n=3), adalimumab (n=5), dapsone (n=3), etanercept (n=1), mycophenolate mofetil (n=1), tocilizumab (n=1). The main clinical symptoms for starting apremilast were oral aphthous ulcers (n=19) and genital ulcers (n=14). Other manifestations present at apremilast onset were arthralgia/arthritis (n=6), folliculitis/pseudofolliculitis (n=6), asthenia (n=5), furunculosis (n=1), erythema nodosum (n=1), erythematous and scaly skin lesions (n=1), psoriasis (n=1), deep venous thrombosis (n=2) and ileitis (n=1). Table 1 shows the evolution of the patients. After a median follow-up of 6 [interquartile range, 5–10] months, most of the patients experienced clinical improvement. In this period of time, 11 patients developed any side-effect: dyspepsia (n=5), nausea (n=4), diarrhoea (n=4), abdominal pain (n=4), headache (n=3), loss of appetite (n=3), weight loss (n=1) and halitosis (n=1). Three patients had to reduce the dose to 30 mg/day. Apremilast was discontinued in 4 patients: because of not obtaining the expected improvement (n=2), due to desire of pregnancy (n=1) and due to development of neurological involvement (n=1).

Abstract FRI0489 – Table 1

	Baseline n=19	Week 1-2 n=19	Week 4 n=19	Month 3 n=18	Month 6 n=11
Resolution of main symptom, oral and/or genital ulcers n, (%)					
Complete		7/19 (36.8)	12/19 (63.1)	13/18 (72.2)	7/11 (63.6)
Partial		8/19 (42.1)	4/19 (21.0)	1/18 (5.5)	3/11 (27.3)
Resolution of other symptoms n, (%)					
Complete		5/13 (38.5)	6/13 (46.1)	8/12 (66.6)	5/7 (71.4)
Partial		1/13 (7.7)	2/13 (15.4)	4/12 (33.3)	2/7 (28.6)
Dose of prednisone (mg/day), median [IQR]	7.5 [0-12.5]	6.2 [0-10]	6.2 [0-10]	3.7 [0-5]	2.5 [0-4]

Conclusions: Apremilast leads to a rapid and maintained improvement in many patients with refractory mucocutaneous ulcers of BD. Even in patients refractory to several systemic drugs including biologic therapy. However, the development of adverse digestive effects is frequent.

Disclosure of Interest: None declared

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FRI0490 MORTALITY AND EARLY SEVERE INFECTION IN PATIENTS WITH ANCA-ASSOCIATED VASCULITIS

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Background: The introduction of treatment regimens comprising of cyclophosphamide or rituximab combined with corticosteroids has brought about dramatic improvements in the prognosis of ANCA-associated vasculitis.¹ Severe infectious events, especially in the early phase of treatment, associated with risk of death have been reported in the past several studies.^{2,3}

Objectives: We retrospectively investigated the association between mortality and early severe infection in patients with antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (AAV), and we also attempted to identify the potential predictors for early severe infection.

Methods: We recruited 182 consecutive hospitalised patients newly diagnosed with AAV at our hospital, from January 2000 to June 2017, in this retrospective cohort study. All cause mortality, relapse, and severe infections within six months after starting treatment (early severe infection) were analysed.

Results: The mean age was 70 years at diagnosis, and the classification according to the Chapel Hill Conference definition were microscopic polyangiitis (MPA) in 82 patients (45.1%), granulomatosis with polyangiitis (GPA) in 36 patients (19.8%), eosinophilic granulomatosis with polyangiitis (EGPA) in 24 patients (13.2%), and renal-limited vasculitis in 32 patients (17.6%).⁴ Median follow up was 158 weeks (range 0–182 w). Using Cox regression analysis, elderly onset (age ≥75 years) AAV ($p=0.027$) and early severe infection ($p<0.001$) were independent predictors of all cause mortality (table 1).

Early severe infection tended to increase among patients who received immunosuppressive therapy of a corticosteroid combined with cyclophosphamide or rituximab (conventional treatment), and this trend was significant in non-severe (BVAS <20) AAV patients ($p=0.030$) (table 2). Treatment response rate ($p=0.058$)

and relapse rate ($p=0.137$) were not significant between the different treatment groups.

Abstract FRI0490 – Table 1. Risk factors affecting survival according to Cox regression analysis

Risk factor	Hazard ratio	95% CI	P value
Age ≥ 75 years old	2.35	(1.1–5.03)	0.027
BVAS [*] ≥ 20	2.08	(0.99–4.32)	0.05
Creatinine ≥ 1.5 mg/dl	1.18	(0.58–2.38)	0.654
Early severe infection	3.23	(1.63–6.48)	<0.001

*Birmingham Vasculitis Activity Score (BVAS) Version.3

Abstract FRI0490 – Table 2. Risk factors affecting early severe infection in non-severe AAV patients

Risk factor	Hazard ratio	95% CI	P value
Age ≥ 75 years old	2.1	(0.85–5.32)	0.105
Conventional treatment	3.0	(1.11–7.89)	0.030
Lung involvement	1.0	(0.43–2.48)	0.936
Creatinine ≥ 1.5 mg/dl	1.0	(0.41–2.33)	0.963

Conclusions: Early severe infection is an independent predictor of death in patients with AAV, and conventional treatment has a potential risk of death due to severe infection. This study supports the current EULAR recommendation that several treatment strategies are recommended according to the disease severity of vasculitis.⁵ AAV patients who receive conventional treatment should be carefully monitored to reduce the occurrence of severe infection, especially in early phase of treatment.

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FRI0491

SMOKING AS A RISK FACTOR FOR GIANT CELL ARTERITIS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: Tobacco smoking is a well-established risk factor for the development of several autoimmune diseases such as rheumatoid arthritis and systemic lupus erythematosus. A similar association between smoking and giant cell arteritis (GCA) has been suspected but remains unclear due to limited study size and conflicting epidemiologic data.

Objectives: To conduct a systematic review and meta-analysis to further investigate the association between smoking and the development of GCA.

Methods: Two investigators (D.B. and M.K.) independently searched published studies indexed in MEDLINE and EMBASE from inception to February 2017 using the terms “giant cell arteritis,” “temporal arteritis,” “cranial arteritis,” and “Horton disease.” Recent conference abstracts available online were also reviewed. The following inclusion criteria were used: 1) original observational study comparing patients with GCA to healthy controls; 2) inclusion of smoking history; 3) provision of absolute numbers and/or statistical comparisons with 95% confidence intervals. Study eligibility was independently determined by the two investigators, with disagreements reviewed by a third investigator (P.U.) and resolved by consensus. RevMan 5.3 software was used for the data analysis. Point estimates and standard errors were extracted from individual studies and were combined by the generic inverse variance method of DerSimonian and Laird. Given the high likelihood of between-study variance, we used a random-effect model rather than a fixed-effect model. Statistical heterogeneity was assessed using the Cochran’s Q test.

Results: The initial search yielded 3312 articles. Of these, thirteen studies (8 prospective and, 5 retrospective case-control studies) with unique cohorts were identified and included in the primary analysis (ever vs. never smoking history). Patients in the GCA cohort were more likely to have a history of smoking with an odds ratio of 1.19 (95% CI, 1.01–1.39) [figure 1A]. Considerable heterogeneity

was present ($I^2=85\%$). Five of these studies included information on current smoking status. One additional study, which only reported current smoking status, was also included. The GCA cohort showed an association with current tobacco use with an odds ratio of 1.18 (95% CI, 1.01–1.38) [figure 1B].

Conclusions: Our study demonstrated a statistically significant increased risk of GCA among smokers compared to non-smokers.

Disclosure of Interest: None declared

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FRI0492

CLINICAL CHARACTERISTICS OF PARENCHYMAL NEURO-BEHCHET'S DISEASE: A RETROSPECTIVE ANALYSIS

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Background: Neurological involvement is one of the most serious complications in Behcet's disease (BD).

Objectives: To investigate the clinical characteristics of parenchymal neuro-Behcet's Disease (pNBD).

Methods: We retrospectively reviewed all the medical records of BD patients who were admitted to our institute between 2000 and 2016. The diagnosis of NBD was based on the 2014 International Consensus criteria for NBD.¹ Eighty-four BD patients without neurological involvement were randomly matched by sex and age as control.

Results: 42 patients (25 male and 17 female) with pNBD accounted for 4.2% of the 1009 hospitalised BD patients during that period. The mean age at BD onset and at neurological onset was (30.1 $\pm$ 11.1 years old and (35.3 $\pm$ 12.1 years old, respectively). The majority of patients developed neurological symptoms after other initial systemic symptoms of BD in a median period of 2 months (range from 0–49). Neurological onset was concomitant with the onset of BD in 6 cases (14.3%). The most frequent location was brainstem (23/42, 54.8%). Spinal cord involvement was presented in five cases, in which four with cervical cord involved. 13 cases suffered from multiple lesions. Pyramidal (21/42, 50.0%) and headache (14/42, 33.3%) were the most common manifestations of pNBD. Lumbar puncture was performed in 40 patients, in which 80% (32/40) of patients had normal pressure and 55% (22/40) had elevated protein levels ((0.51 $\pm$ 0.24) g/L). Compared with the controls, the prevalence of ocular involvement (uveitis, retinal vasculitis, scleritis) was significantly higher in pNBD (35.7%) ($p=0.041$, OR=2.36, 95% CI=1.03–5.44) (table 1). Cranial MRI in 32 patients showed the lesions were mainly in the midline structures, including brainstem (22/42, 52.4%), periventricular (13/42, 31.0%), centrum semiovale (8/42, 19.0%). Typically, the lesions were in hypersignal in T2. All pNBD patients received corticosteroids (≥ 1 mg/kg/d) and 23 patients (54.8%) received the pulse dose (1 g/d). Cyclophosphamide was the most commonly used immunosuppressant (39/42) and 10 cases took more than one immunosuppressants (including methotrexate and azathioprine). Biological agents were administered in six refractory pNBD patients, including Infliximab in 4 cases, Tocilizumab in 1 case, and Interferon- $\alpha 2a$ in 1 case. Intrathecally injection of dexamethasone 10 mg and methotrexate 10 mg was given to 28 patients. With a median follow-up of 28 months (4 to 156 months), 22 patients (52.4%) achieved clinical improvements, while 10 patients (23.8%) relapsed and 4 patients died (the mortality was 9.5%). Six patients lost to follow up.