follows: IFX (n=12) (5 mg/kg 0, 2 y 6 weeks and every 4–8 weeks) and ADA (n=22) (40 mg/sc/2 weeks). We observed a rapid and sustained improvement in macular thickness after 1 year follow-up in both groups, without objectifying significant differences between them. In the same way, secondary ocular parameters also improved (table 1).

Abstract FRI0498 – Table 1

	TCZ	Anti-TNF- α	P
Baseline			
BCVA	0.40 $\pm$ 0.31	0.48 $\pm$ 0.31	0.98
Tyndall	1 [0-1]	1 [0-2]	0.13
Vitritis	1 [0-2]	1 [0-3]	0.07
OCT	431.82 $\pm$ 165.99	397.18 $\pm$ 138.12	0.21
1st month			
BCVA	0.50 $\pm$ 0.30	0.61 $\pm$ 0.28	0.58
Tyndall	0 [0-0]	0 [0-0]	0.47
Vitritis	0 [0-0.5]	0.5 [0-1]	<0.01
OCT	330.86 $\pm$ 104.21	328.41 $\pm$ 86.53	0.25
6th month			
BCVA	0.56 $\pm$ 0.33	0.71 $\pm$ 0.31	0.73
Tyndall	0 [0-0]	0 [0-0]	0.04
Vitritis	0 [0-0.5]	0 [0-0]	<0.01
OCT	275.07 $\pm$ 73.80	264.90 $\pm$ 45.92	0.006
1st year			
BCVA	0.59 $\pm$ 0.33	0.72 $\pm$ 0.32	0.76
Tyndall	0 [0-0]	0 [0-0]	<0.01
Vitritis	0 [0-0.5]	0 [0-0]	0.36
OCT	259.10 $\pm$ 49.51	261.42 $\pm$ 37.71	0.14

Conclusions: TCZ and Anti-TNF- α are effective in the treatment of CME refractory to conventional therapy.

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FRI0499

A MULTINATIONAL QUALITATIVE STUDY IN GIANT CELL ARTERITIS: PATIENT PERCEPTIONS OF DIAGNOSIS, TREATMENT, IMPACT ON HEALTH-RELATED QUALITY OF LIFE AND CONTEXTUAL FACTORS

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Background: Giant cell arteritis (GCA) is the commonest form of systemic vasculitis caused by inflammation of the blood vessels around the head and neck, with the highest incidence in women aged 70–79 years (7.4 per 10 000 person-years). Patients present with headache, jaw claudication and polymyalgia rheumatica with visual loss in 20%. Treatment is with high dose glucocorticoids.

Objectives: Identify and define the range of patient experiences in relation to GCA, and effects on health related quality of life in patients from the United Kingdom and Australia.

Methods: Semi-structured qualitative interviews with patients from the UK and Australia explored health-related quality of life and patient perspectives on the experience of GCA. Interviews were recorded, transcribed and analysed. Patients were purposively sampled to include both genders, a range of disease durations and organ involvement (visual loss and large vessel involvement). Data were analysed with inductive thematic analysis and managed using NVivo 10. The sample size was determined by the point at which no new substantive themes emerged.

Results: Thirty-one interviews were conducted. Demographics and disease features shown in table 1. Individual sub-codes were identified then grouped into overarching themes: "Anxieties around getting a diagnosis of GCA", "Description of symptoms related to GCA and its treatment", "Lack of bodily strength, stability and stamina; difficulties with completing daily tasks", "Difficulties with participating in social activities, work and caring roles", "Not feeling normal and impact on general perception of health", "Anxiety and fear of the future". Contextual factors impacted on how patients experienced GCA including "Response to treatment and adverse effects", "Receiving support from family, friends and health care workers", "Adopting successful self-management techniques, e.g. keeping fit and active" and "Presence of pre-existing co-morbidities and development of secondary conditions e.g. cardiovascular disease, osteoporosis or diabetes".

Demographics		United Kingdom (n=25)	Australia (n=6)	Total (n=31)
Sex, n (%)	Male	9 (36.0)	1 (7.7)	10 (32.3)
	Female	16 (64.0)	5 (92.3)	21 (67.7)
Age, n (%)	<70 years	5 (20.0)	3 (50.0)	8 (25.8)
	≥70 years	20 (80.0)	3 (50.0)	23 (74.2)
	Mean	75	69	74
Diagnostic test, n (%) *	Biopsy	21 (84.0)	5 (83.3)	26 (83.9)
	Ultra/S	5 (20.0)	0 (0)	5 (16.1)
Visual Loss (%)	CTA	2 (8.0)	0 (0)	2 (6.45)
	PET	2 (8.0)	1 (16.7)	3 (9.68)
	Yes	10 (40.0)	2 (33.3)	12 (38.7)
ESR≥50 or CRP≥10	Yes	24 (96.0)	5 (83.3)	29 (93.6)
Time from diagnosis, n (%)	<1 year	13 (52.0)	4 (66.7)	17 (54.8)
	≥1 year	12 (48.0)	2 (33.3)	14 (45.2)
Disease Active, n (%)	Yes	11 (44.0)	4 (66.7)	15 (48.4)
	No	14 (56.0)	2 (33.3)	16 (51.6)
Flare<1 year, n (%)	Yes	13 (52.0)	3 (50.0)	16 (51.6)
	No	10 (40.0)	3 (50.0)	13 (41.9)
	Never	2 (8.0)	0 (0)	2 (6.5)

Conclusions: Patients with GCA have described a range of themes of interest in relation to their disease. These data could be used as the basis of developing a patient reported measure of outcome in GCA.

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FRI0500

EXTRACRANIAL VASCULAR AFFECTION IN GIANT CELL ARTERITIS

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Background: Giant cell arteritis (GCA) is a large vessel vasculitis with a predisposition for the cranial branches of the external carotid artery. However, aorta and/or its main branches may also be involved (1–3).

Objectives: To assess the vascular territories most frequently affected in a series of patients with GCA who presented extracranial vessel involvement.

Methods: Retrospective study of patients with GCA who presented compromise of extracranial vessels confirmed by PET/CT. Visual analysis of vascular uptake was performed on supra-aortic trunks (SAT), aortic arch (AA), thoracic aorta (TA), abdominal aorta (AA), iliac arteries (IA), lower limb arteries (LLA), and upper limb arteries (ULA). We carried out a comparative study between both sexes to see if there was any difference in the pattern of affection.

Results: We evaluated 68 patients with GCA (51W/17M) with a mean age of 68.06±8.33 years. The vascular territories affected were: TA (n=58, 85.29%), SAT (n=38, 55.88%), AA (n=28, 41.18%), AA (n=18, 26.47%), LLA (n=17, 25%), IA (n=13, 19.12%) and ULA (n=6, 8.82%). We also made a study of the number of vascular territories affected: 1 vascular territory (n=13, 19.12%), 2 territories (n=22, 32.35%), 3 territories (n=18, 26.47%), 4 territories (n=12, 17.65%) and more than 4 territories (n=3, 4.41%). Likewise, a comparative study between both sexes was conducted, in which only statistical significance was achieved in the involvement of ULA, which was more frequent in men (table 1).

Abstract FRI0500 – Table 1

	Men (n= 17)	Women (n= 51)	p
Age, mean ± SD	69.3 ± 8.5	67.6 ± 8.6	0.48
Vascular territories affected, n (%)			
Supra-aortic trunks	8 (47.1)	30 (58.8)	0.57
Aortic arch	4 (23.5)	14 (27.4)	0.99
Thoracic aorta	12 (70.6)	46 (90.2)	0.11
Abdominal aorta	6 (35.3)	22 (43.1)	0.78
Iliac arteries	1 (5.9)	12 (23.5)	0.21
Upper limb arteries	4 (23.5)	2 (3.9)	0.04
Lower limb arteries	6 (35.3)	7 (13.7)	0.11
Number of vascular territories affected, n (%)			
1	5 (29.4)	8 (15.7)	0.37
2	5 (29.4)	20 (39.2)	0.66
3	5 (29.4)	13 (25.5)	0.99
4	1 (5.9)	11 (21.6)	0.27
>4	1 (5.9)	2 (3.9)	0.73

Conclusions: In patients with GCA the involvement of TA is very frequent, followed by the SAT and the AA. To a lesser extent, the AA and the LLA vessels are affected. The involvement of the IA and the ULA vessels is less frequent; the latter more frequently in men. On the other hand, the involvement of 2–3 vascular territories are the most frequent patterns.

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FRI0501 **NEGATIVE TEMPORAL ARTERY BIOPSIES: COMPARISON BETWEEN BIOPSY-NEGATIVE GCA AND NON-GCA PATIENTS**

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Background: Temporal artery biopsy (TAB) plays a key role in diagnosis of giant cell arteritis (GCA). However, approximately 15%–20% of patients ultimately diagnosed with GCA have negative biopsies. Among patients with negative TAB, it is often challenging to identify patients with GCA from those with an alternate (non-GCA) diagnosis.
Objectives: To compare TAB-negative GCA with patients receiving a non-GCA alternate diagnosis.
Methods: Two cohorts were retrospectively identified through direct medical record review. The first cohort consisted of patients with TAB-negative GCA diagnosed between 1/1/1998 and 12/31/2013. The second cohort included all patients with a negative TAB performed between 1/1/2009 and 12/31/2010 in which a non-GCA alternate diagnosis was provided after a minimum of 6 months of follow up. Final diagnoses were confirmed by consensus among two rheumatologists and a

physician abstractor. Baseline characteristics were compared between the two cohorts using chi-square and rank sum tests.
Results: 110 patients with TAB-negative GCA and 195 non-GCA patients with a negative TAB were identified. Alternate diagnoses for non-GCA patients are listed in table 1. Age, sex, number of days on glucocorticoids prior to biopsy, and biopsy length were similar in both groups. Time from first symptom to diagnosis was longer in non-GCA patients [mean (SD); 2.6 (2.5) vs 1.5 (2.1) months; p<0.001] and fewer non-GCA patients fulfilled ≥3 ACR criteria for GCA (27% vs 64%; p<0.001). Although headache was the primary symptom in both cohorts (66% TAB-negative GCA; 68% non-GCA), patients with biopsy-negative GCA had more frequent anorexia, fatigue, fever, polymyalgia rheumatica, temporal artery tenderness and claudication (jaw, arm, or leg). Baseline transient (5% TAB-negative GCA; 6% non-GCA; p=0.58) and permanent (3% TAB-negative GCA; 3% non-GCA; p=0.86) vision loss were infrequently observed. ESR was higher in TAB-negative GCA patients [64.0 (35.1) vs 55.2 (67.4); p=0.002] compared to non-GCA patients but CRP did not differ [44.3 (53.6) vs 43.8 (61.9); p=0.39].

Abstract FRI0501 – Table 1

Alternate diagnosis, n (%)	Negative biopsy with alternate diagnosis (N=195)
Neurologic condition	75 (38%)
Isolated PMR	38 (19%)
Rheumatic disease other than PMR or GCA	26 (13%)
Non-arteritic AION	10 (5%)
Fever of unknown origin	9 (5%)
Infectious disease	7 (4%)
Non-malignant hematologic condition	7 (4%)
Malignant disease	6 (3%)
Other vasculitis	6 (3%)
Cervical arthritis	5 (3%)
Systemic disease of unknown etiology	5 (3%)
Other	1 (1%)
AION: anterior ischemic optic neuropathy; GCA: giant cell arteritis; PMR: polymyalgia rheumatica	

Conclusions: In this cohort, neither headache nor vision loss at presentation were associated with an ability to discriminate between diagnosis of TAB-negative GCA compared to patients without GCA. ACR criteria may be helpful in identifying patients with TAB-negative GCA. Among patients with negative TAB, constitutional symptoms and claudication (jaw/limb) were more frequently associated with an ultimate diagnosis of TAB-negative GCA.
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FRI0502 **RISK OF CANCER IN PATIENTS DIAGNOSED WITH GIANT CELL ARTERITIS IN WESTERN NORWAY 1972–2012**

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Background: A meta-analysis from 2014 reported a low but statistically significant increased malignancy risk among patients with giant cell arteritis (GCA), but individual epidemiological studies have shown conflicting results.
Objectives: To determine the risk of cancer in GCA patients during a 41 year period.
Methods: Hospital-based retrospective cohort study including patients diagnosed with GCA in Bergen Health Area during 1972–2012. Patients were identified through computerised hospital records using the International Classification of Diseases (ICD)-coding system. Clinical information was extracted from patients' medical journals. We excluded patients if data were unavailable, if the reviewing rheumatologist found GCA to be an implausible diagnosis or if the American College of Rheumatology (ACR) 1990 classification criteria for GCA were not fulfilled. Each patient was matched for age, sex, and county of residence to 3 control subjects randomly selected from the Central Population Registry of Norway. Information on the occurrence of cancer was obtained from the Cancer Registry of Norway. The cumulative incidence of malignancy in cases and controls were estimated using Kaplan-Meier plots.
Results: The patient inclusion process and patient characteristics have been published previously.² A total of 792 patients were included, 566 (71.5%) women (mean age 73.5 years, SD 8) and 226 (28.5%) men (mean age 72.1, SD 9). There were 2314 matched controls (excluding duplicate controls and control subjects