IgAV compared to healthy blood donors (HBD), and determine associations with IgAV clinical signs.

Methods: Flow cytometry of stained, lysed and fixed whole blood was performed in IgAV (n=30), and HBD (n=17) (Miltenyi). Cytokines were quantitated by multiplex bead assay (Luminex), ELISA (IL-6) and immunonephelometry (acute phase serum amyloid A (SAA)) in 57 IgAV vs. 53 HBD.

Results: Percentage of CD16⁺ neutrophils was significantly higher, while percentages of CD3⁺ T-cells (including CD4⁺ and CD8⁺ cells), as well as CD19⁺ B-cells were significantly lower in peripheral blood of IgAV patients vs. HBD. The expression of I-selectin (CD62L) on CD16⁺ neutrophils was significantly increased in IgAV vs. HBD, as were the sera levels of TNF- α (2-fold), IL-6 (3-fold), IL-8 (2.2-fold) and SAA (11.7-fold changed levels) (table 1). Association was found between GIT involvement and lower neutrophil expression of integrin α M (CD11b) (median; IQR: 7.2; 4.2–16.0), compared to skin limited (17.8; 9.9–40.5) IgAV cases (p=0.047). There was no association found between different cytokines and IgAV clinical phenotype.

Abstract FRI0516 – Table 1. Cell profiles, neutrophil surface proteins and cytokines in IgAV patients compared to HBD

Cells (% of WBC)	MEDIAN (Q ₂₅ – Q ₇₅)		P value	Cytokines (pg/ml)	MEDIAN (Q ₂₅ – Q ₇₅)		P value
	HBD (n=15)	IgAV (n=15)			HBD (n=53)	IgAV (n=57)	
Neutrophils	51.0 (47.1– 56.9)	67.5 (63.6– 73.3)	<0.001	IL-1 β	0.4 (0.4– 0.4)	0.4 (0.4– 1.5)	ns
T-cells	26.4 (23.0– 31.8)	16.6 (10.2– 21.4)	<0.001	IL-6	2.0 (1.0– 6.0)	6.0 (2.8– 14.3)	0.015
CD4⁺T cells	13.6 (11.7– 18.4)	10.4 (7.7– 14.4)	0.003	IL-8	53.3 (10.9– 195.0)	117.1 (29.3– 443.9)	0.018
CD8⁺T cells	10.3 (6.0– 12.6)	5.0 (1.9– 7.9)	0.002	IL-9	19.0 (19.0– 19.0)	19.0 (19.0– 19.0)	ns
B-cells	3.8 (2.9– 4.7)	2.4 (1.6– 2.9)	0.006	IL-10	1.0 (0.8– 2.8)	0.04 (0.04– 1.3)	ns
NK cells	4.6 (3.8– 6.3)	3.6 (2.3– 6.1)	ns	IL-13	665.2 (354.1– 1668.0)	23.0 (23.0– 102.2)	ns
Neutrophil surface proteins (MFI)	HBD (n=17)	IgAV (n=30)		IL-23	1.4 (1.4– 82.9)	1.4 (1.4– 118.6)	ns
CD62L	56.4 (44.9– 73.7)	86.5 (45.4– 107.5)	0.036	TNF-α	3.9 (0.8– 15.5)	8.1 (3.0– 20.2)	0.003
CD11b	8.7 (5.5– 27.4)	15.7 (6.4– 31.3)	ns	SAA (μg/ ml)	2.8 (1.9– 4.7)	32.8 (7.2– 168.0)	<0.001

Conclusions: We found significant up-regulation of neutrophils and their CD62L expression, as well as sera levels of IL-6, IL-8, TNF- α and SAA in IgAV, implying a pathogenic role of neutrophils in IgAV. CD11b might represent a promising surface marker of GIT involvement in adult IgAV.

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FRI0517

VESSEL WALL MORPHOLOGY IN GIANT CELL ARTERITIS– A LONGTERM SONOGRAPHIC FOLLOW-UP STUDY

E. Schegg¹, C.T. Berger², S. Imfeld³, D. Staub³, M. Recher⁴, D. Kyburz¹, M. Aschwanden³, T. Daikeler¹. ¹Department of Rheumatology; ²Translational Immunology, University Hospital Basel; ³Department of Angiology; ⁴Clinical Immunology, Basel, Switzerland

Background: Ultrasound (US) is a cornerstone in the diagnosis of GCA. Only limited data on how US documented large vessel wall thickening changes during treatment is available.

Objectives: To assess arterial vessel wall findings by US during long term follow-up in GCA patients with large vessel vasculitis (LVV) and to correlate findings with the disease course

Methods: Patients with GCA and US defined LV vasculitis were scheduled semi-annually for clinical and laboratory assessment as well as US of the temporal (TA), vertebral (VA), carotid (common, internal, external), subclavian (SA), axillary (AXA), deep (DFA), superficial (SFA) and common (CFA) femoral, and popliteal arteries (PA). US findings were classified as normal, moderate or marked vessel wall thickening.

Results: From 42 patients (16 male) with a median age of 75 years at diagnosis 28 had typical vessel wall thickening in the temporal artery and in at least one LV segment and 14 in the LV only. The following vessels (marked/moderate) were most often involved: PA in 11/21, SFA in 13/20, AxA in 14/5, SA in 8/13 patients respectively.

A reduction of the vessel wall thickening in the temporal artery during follow-up was found in 79% of patients after in median 7 months, with bilateral normalisation in 10 patients after in median 13 months.

In contrast 55% had no, 43% a partial and only one patient a complete reduction of thickening of all LV walls during follow-up. From initially marked supra-aortic LV segments 35% were moderate and 16% normal and from initially moderate LV 13% were normal at 1 year FU. From initially marked infra-aortic LV segments 36% were moderate and 3% normal and from initially moderate 10% were normal at 1 year FU.

Progression of vessel wall thickening in the LV during FU was seen in a total of 3 patients, in 2 of those, a clinical relapse of GCA was diagnosed one respectively 2 months before US.

There was no difference between patients with reduction of the vessel wall thickening and without during follow-up in respect to clinical parameters (relapse rate over the observation time, cumulative steroid dose after one year).

Conclusions: Regression of US morphological documented thickening of LV in patients with GCA is rare despite clinical remission. US remains sensitive for the diagnosis of LVV long after treatment initiation. Most plasticity is seen in the TA and more rarely in the supra-aortic segments.

Disclosure of Interest: None declared

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FRI0518

INCIDENCE, CHARACTERISTICS AND MANAGEMENT OF GIANT CELL ARTERITIS IN FRANCE: A STUDY BASED ON NATIONAL HEALTH INSURANCE CLAIMS DATA

V. Devauchelle Pensec¹, E. Hachulla², M. Paccalin³, S. Gandon⁴, I. Idier⁵, M. Nolin⁶, M. Belhasen⁶, A. Mahr⁷. ¹Rheumatology, University Hospital, Brest; ²Internal Medicine, University Hospital Claude Huriez, Lille; ³Internal Medicine, University Hospital, Poitiers; ⁴Clinical Operations, Roche SAS, Boulogne Billancourt; ⁵Medical, Chugai Pharma France, Paris La Defense; ⁶PELyon; EA 7425 HESPER, Université Claude-Bernard-Lyon1, Lyon; ⁷Internal Medicine, University Hospital APHP Saint Louis, Paris, France

Background: Giant cell arteritis (GCA) is an immune-mediated, primary systemic vasculitis that affects large and medium-sized arteries. GCA may cause vision loss in up to 20% and requires long term glucocorticoids (GCs). There are currently few data available in France on the epidemiology, patients' (pts) characteristics, diagnosis and management of GCA in a real-world setting.

Objectives: The objectives of this study were to address these questions using Health insurance claims data.