dyspepsia (n=9), abdominal pain (n=7), headache (n=5), loss of appetite (n=4), weight loss (n=3), halitosis (n=1), dry mouth (n=1), palpitations (n=1) and/or depression (n=1). Six patients had to reduce the dose to 30 mg/day. APR was discontinued in 11 patients due to: not obtaining the expected improvement (n=5), intense gastrointestinal adverse effects (n=3), desire of pregnancy (n=1), persistent erythema nodosum (n=1) and development of neurological involvement (n=1).

Conclusion: Our data show a rapid and maintained improvement with APR in patients with mucocutaneous ulcers of BD refractory to several systemic drugs, including biologic therapy.

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TABLE. Evolution of main symptoms and reduction prednisone dose with apremilast therapy.

Outcome of oral and/or genital ulcers n, (%)	Baseline	Week 1-2 n=47	Week 4 n=43	Month 3 n=37	Month 6 n=28	Month 12 n=12	Month 18 n=4	Month 24 n=2
Complete resolution	18 (38.3)	30 (63.8)	31 (72.1)	20 (54.1)	6 (50)	3 (75)	2 (100)	0
Partial resolution	24 (51.1)	10 (21.3)	2 (5.4)	7 (25)	6 (50)	1 (25)	0	0
No response	5 (10.6)	3 (7)	4 (10.8)	1 (3.6)	0	0	0	0
Dose of prednisone (mg/day), median [IQR]	10 [5-15]	10 [5-15]	10 [5-12.5]	5 [2.5-7.5]	5 [2.5-10]	2.5 [2.5-5]	2.5 [2.5-5]	0 [0-0]

*p<0.05

n=available data.

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SAT0216

PATIENT PERCEPTIONS OF PHYSICAL ACTIVITY AFTER A DIAGNOSIS OF GIANT CELL ARTERITIS: A SECONDARY ANALYSIS OF MULTINATIONAL QUALITATIVE DATA

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Background: Giant cell arteritis (GCA) is the most common vasculitis in the UK, with an incidence of 220 cases/million in adults over 50 years of age. The physical symptoms as well as the side effects of glucocorticoids may impact patients' ability to exercise. Maintaining physical activity

(PA) has been shown to be beneficial to disease activity in other inflammatory conditions, and is also a specific priority for GCA patients.

Objectives: To explore patient perceptions of physical activity in GCA.

Methods: Multinational qualitative study, using interviews with 36 patients from the UK (25) and Australia (11), all of whom had a definitive diagnosis from imaging or biopsy. Interviews were recorded, transcribed, and analysed using inductive thematic analysis. This is secondary analysis of data collected to explore health-related quality of life in people with GCA.

Results: 84 individual themes were reported by patients, each of which fell broadly into two overarching themes: barriers to and facilitators of physical activity. Within each theme, four subthemes were identified. In terms of barriers, these were: negative physical symptoms (including visual loss, fatigue, weakness, pain and stiffness), lack of physical capability (including poor stamina, confidence and mobility), negative perceptions around PA, and negative reinforcement (i.e. new physical symptoms following PA). Facilitators of physical activity were also grouped into four subthemes: external facilitators (including motivation from healthcare professionals and support groups), access to appropriate facilities, personal strategies (including pacing and goal-setting) and personal facilitators (including internal motivation to improve symptoms, and positive reinforcement from PA).

Conclusion: There are a variety of barriers to physical activity in GCA patients, including patients being fearful of exercise. In other inflammatory conditions, patients report improved symptoms following physical activity as well as wider benefits to general wellbeing and cardiovascular health. Education, motivational interviewing, and personalised strategies may be beneficial components of an intervention to support physical activity in patients with GCA.

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SAT0217

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS: CLINICAL PREDICTORS OF LONG-TERM ASTHMA SEVERITY

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Background: Bronchial asthma in Eosinophilic Granulomatosis with Polyangiitis (EGPA) patients is commonly present before, at and after the diagnosis of vasculitis, often requiring high doses of oral corticosteroid (OCS) to be controlled.

Objectives: We aimed to better characterize long-term asthma in EGPA and to identify predictors of long-term asthma severity.

Methods: Retrospective cohort study of anti-neutrophil cytoplasmic antibodies associated vasculitis patients who fulfilled standardized criteria for EGPA (American College of Rheumatology 1990 and/or Lanham criteria and/or Chapel Hill Consensus Conference 2012) that were followed in a single referral center from 1990-2017. Baseline and 3 (±1) years of follow-up clinical, laboratory and pulmonary function data were analyzed. The definition from American Thoracic Society Workshop was used to identify patients with severe/uncontrolled asthma. Severe rhinosinusitis was defined as rhinosinusitis that needed sinus surgery to control nasal polyps and/or reduce symptoms (≥1 surgery).

Results: One-hundred-eighty-seven patients with EGPA were identified, from which 89 patients with documented asthma assessment at baseline and after 3 years from diagnosis were included. Severe/uncontrolled asthma was observed in 42.7% of patients at diagnosis and was associated with a previous history of respiratory allergy ($p<0.01$), higher serum total IgE levels ($p<0.05$), and increased use of high dose inhaled corticosteroids (ICS) ($p<0.05$) and OCS ($p<0.001$) for respiratory symptoms the year before the diagnosis of EGPA. Improvement or worsening of asthma during follow-up was experienced by 22.4% patients, with no discriminative baseline features that allowed their distinction. Severe/uncontrolled asthma was present in 40.5% of patients at 3 years, and was associated with increased airway resistance on pulmonary function testing ($p<0.05$). Long-term PFT did not improve during long-term follow-up regardless of ICS and OCS therapy (both FEV1/FVC and FEV1, $p>0.05$). Using multivariate binary logistic regressions, severe rhinosinusitis, pulmonary infiltrates, overweight and severe/uncontrolled asthma at vasculitis diagnosis independently predicted severe/uncontrolled asthma at the 3-year endpoint (Table below).

Table. Multiple binary logistic regressions of baseline variables associated with severe/uncontrolled asthma at 3 (± 1) years of follow-up

Variables	Odds Ratio	95% Confidence of Interval	p value
Severe/uncontrolled asthma	10.64	3.43-39.08	<0.001
Pulmonary infiltrates	5.16	1.43-21.85	0.011
Severe rhinosinusitis	3.57	1.07-13.55	0.038
Overweight (BMI ≥ 25 kg/m ²)	3.41	1.05-12.90	0.041

Conclusion: In this large cohort of patients with EGPA, long-term severe/uncontrolled asthma is frequent, and patients affected display a higher proportion of bronchial obstruction and have more severe airway resistance. Overall, pulmonary function does not improve during the follow-up regardless of ICS and OCS therapy. Finally, long-term severe/uncontrolled asthma is associated with baseline pulmonary and ENT manifestations, but not with vasculitic features.

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SAT0218 PATIENTS' JOURNEY THROUGH GIANT CELL ARTERITIS: A QUALITATIVE STUDY

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Background: Giant cell arteritis (GCA) is the most common form of vasculitis. Diagnosis is difficult due to multiple presenting symptoms: headache, jaw and limb claudication, myalgia and visual impairment. Access to care may be delayed because often multiple providers are involved in the diagnosis of GCA and disease management. Treatment with high-dose glucocorticoids (GCs) can relieve symptoms and prevent vision loss, but GC-related adverse events are common; GCA often relapses once GCs are tapered.

Objectives: To understand the GCA patient care pathway and unmet needs in GCA through in-depth patient interviews.

Methods: US patients with GCA were recruited through outreach to physicians and The Vasculitis Foundation, which used email newsletters and social media to recruit $\approx 50\%$ of participating patients. Extensive

individual interviews with patients were conducted by qualitative researchers by phone or in person and explored patients' perspectives and experiences from the onset of GCA symptoms to diagnosis and disease management. Patients were asked open-ended questions and encouraged to share their stories to provide additional insights into the patient journey and their individual perspectives. The qualitative data collected were analyzed using human-centered design methodology, including patient typologies (personas: optimist, fearful, stoic or despondent), forced temporal zoom (journey maps), forced semantic zoom (stakeholder system mapping) and affinity mapping for pattern recognition of unmet needs.

Results: A total of 28 patients were interviewed; 23 (82%) were women and mean age was 69 years (Table). The number of patients in each persona category is shown in the Table. Stoic and optimist personas had medium to high levels of self-advocacy and a positive/engaged attitude about their condition, while fearful and despondent personas had low levels of self-advocacy with disengaged/negative attitudes toward their condition. Patients often ascribed their milder GCA symptoms to causes such as stress and did not consult a physician until they developed moderate to severe symptoms, such as persistent headache, jaw pain or visual disturbances. Patients with existing inflammatory disorders were less likely to share symptoms of GCA unless the symptoms substantially worsened. In most cases, physicians diagnosed GCA based on abnormal erythrocyte sedimentation rate, often followed by a temporal artery biopsy. After diagnosis of GCA, all patients received GCs with little information on the chronicity of GCA. Few patients were offered treatment alternatives to GCs. Overall, patients managed their GCA independently, with moderate support from friends or family, and sought to balance relief of GCA symptoms with the adverse effects of GCs. Patients concentrated on tapering and discontinuing GCs, with less concern about relapse. Furthermore, patients who were most uncomfortable with the adverse effects of GCs often waited until their GCA symptoms became debilitating before telling their physician. Almost all patients reported searching for a support group after the diagnosis.

Conclusion: Patients with GCA experience adverse effects from GCs and remain focused on reducing their GC dose. For those with inflammatory comorbidities, diagnosis of GCA is another burden in a debilitating journey that results in a sense of disempowerment and resignation toward their condition and paucity of therapeutic options. Patients with GCA want a clearer understanding of treatment options and need access to support groups. Patients' attitudes and self-advocacy vary depending on their personas; recognizing these personas may help HCPs coordinate patient care. Increased awareness of GCA among patients and HCPs may accelerate the path to diagnosis and treatment, and emerging therapies may help reduce GC burden.

Table. Demographics of Patients With GCA Who Participated in Interviews and Personas Based on Analysis of Qualitative Interview Data

	Patients N = 28
Age, mean, years	69
Women, n (%)	23 (82)
Interview type, n (%)	
Phone	15 (54)
In person	13 (46)
US region, n (%)	
Midwest	10 (36)
Northeast	6 (21)
South	5 (18)
Mid-Atlantic	4 (14)
West	3 (11)
Persona, n (%)	
Optimist	9 (32)
Despondent	9 (32)
Fearful	8 (29)
Stoic	6 (21)

* Some interviewees fit into multiple personas.

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