Compared with patients diagnosed at respiratory medicine, patients diagnosed at rheumatology had a higher frequency of fever (33.3% vs. 0), rash (33.3% vs. 4.5%), arthralgias (19.0% vs. 0) and limb numbness (57.1% vs. 22.7%), but lower frequency of asthma-like symptoms (66.7% vs. 100%; all $P < 0.05$). There were more patients diagnosed at rheumatology received treatment of glucocorticoid (100% vs. 72.7%), immunosuppressive agents (85.7% vs. 4.5%) and intravenous immunoglobulin (28.6% vs. 0) than those diagnosed at respiratory medicine (all $P < 0.01$). Patients diagnosed at rheumatology also received higher initial dose of glucocorticoid than those diagnosed at respiratory medicine [50(50~100) mg/d vs. 28(10~40) mg/d of prednisone dosage, $P < 0.001$].

4) Among the 21 patients diagnosed at rheumatology, 14(66.7%) had asthma-like symptoms, who showed significant longer time required for diagnosis than those without asthma-like symptoms [36(24~120) months vs. 2(2~13) months, $P = 0.020$], but showed no significant difference of onset age between these two groups ($P > 0.05$).

5) The median revisited Five-Factor Score (FFS) was 0(0~1). There were 17(37.8%) patients had FFS ≥ 1 , who had older diagnostic age than those with FFS=0 [65(46~68) years vs. 48(42~53) years, $P < 0.05$], but with no significant difference of onset age or time required for diagnosis. Patients with FFS ≥ 1 had higher level of serum IgE [1280(515~4895) IU/mL vs. 243(72~587) IU/mL] than those with FFS=0 ($P < 0.05$).

Conclusion: Clinical manifestations of EGPA were different between rheumatology and respiratory medicine. Rheumatologist may be more aggressive treating EGPA patients with glucocorticoid and immunosuppressive agents than respiratory physician. Multidisciplinary team is needed for the diagnosis and management of EGPA.

Acknowledgement: This work was supported by Guangdong Medical Scientific Research Foundation (grant no. A2017093) to Le-Feng Chen.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.5369

AB0580

A VISION OF THE CHARACTERISTICS AND COMORBIDITIES OF GIANT CELL ARTERITIS FROM THE HOSPITAL RECORDS OF THE NATIONAL HEALTH SYSTEM

Carmen de Frutos Fernández¹, Maria Angeles Martinez Huedo², Irene Monjo³, Eugenio de Miguel³. ¹Medicine Student Universidad Autónoma de Madrid. Rheumatology service, Hospital Universitario la Paz-IdiPaz., Madrid, Spain; ²U. Docencia e Investigación. Hospital Universitario La Paz. Madrid, Madrid, Spain; ³Rheumatology service, Hospital Universitario la Paz-IdiPaz., Madrid, Spain

Background: Giant cell arteritis (GCA) is the most frequent systemic vasculitis in older than 50 years old, with serious repercussions on the quality of life and survival of patients. The low prevalence and heterogeneous presentation make progress in the diagnostic and the knowledge of the disease difficult.

Objectives: The objective of this study has been to gather a large database to analyze the epidemiological characteristics, the comorbidities and the causes of mortality associated with the hospitalizations by ACG in our country.

Methods: Retrospective observational study based on data from the Database of Hospital from the Spanish National Health Service with primary or secondary diagnostic of GCA between January 1st, 2005 and December 31st, 2015. The included variables were sex, age, main reason for admission, secondaries diagnostics, time of stay, costs, comorbidities, temporal artery biopsy and mortality.

Results: The study cohort included 29.576 patients with GCA, 18.568 (62.8%) women, and the mean age was 80 ± 8 years. The number of hospital admissions with this diagnostic has increased between 2008 and 2013 with an annual cumulative increase rate of 3%, passing from 2.487 to 2.997 patients/year. We have found a different disease affection pattern in men and women in terms of distribution by age group and the comorbidities associated. We have found that the mortality risk increases with the age and with the presence of cardiovascular disease OR 1,816 (1,484-2,221), ischemic heart disease OR 1,590 (1,302-1,941), renal disease OR 1,386 (1,225-1,569) and cancer OR 2,428 (2,039-2,891). While, a decrease in the risk of death was observed in patients who associated polymyalgia rheumatica OR 0.682 (0, 5810,801).

Table 1. Comorbidities and mortality in hospitalized with ACG

	Men		Woman		Both sexes	
	N	%	N	%	N	%
DM2 *	2948	26,8%	4669	25,1%	7617	25,8%
PMR *	1474	13,4%	2715	14,6%	4189	14,2%
ICC*	1298	11,8%	2854	15,4%	4152	14%

ENF.	1556	14,1%	2413	13,0%	3969	13,4%
RENAL *						
Cancer	809	7,3%	499	2,7%	1308	4,4%
IHD *	626	5,7%	565	3,0%	1191	4%
ECV *	502	4,6%	651	3,5%	1153	3,9%
EPOC	289	2,6%	559	3,0%	848	2,9%
CCI*	No					
	4833	43,9%	9174	49,4%	14008	47,4%
comorbidities						
≤ 2	5635	51,2%	8697	46,8%	14332	48,5%
Comorbidities						
> 2	539	4,9%	697	3,8%	1236	4,2%
Comorbidities						
Mortality	712	6,5%	1083	5,8%	1795	6,1%

*Statistically significant differences ($P < 0.05$) DM2: Diabetes mellitus Type 2 PMR: Polymyalgia rheumatica ICC: Congestive heart failure IHC: ischemic heart disease ECV: Cerebrovascular disease CCI: Charlson Index of Comorbidities

Conclusion: In recent years the number of GCA hospital admissions has increased. The presence of comorbidities is high and greater in men. An increase in deaths for ischemic cause and a reduction of mortality in patients with PMR associated is observed.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.3246

AB0581

AN ATYPICAL PRESENTATION OF GIANT CELL ARTERITIS WITH SCALP LUMPS: A CASE REPORT

Uthpala Dissanayake, Risniya Hassan. District General Hospital, Kegalle, Sri Lanka

Background: Giant cell arteritis (GCA) also referred as temporal arteritis is a systemic inflammatory vasculitis of unknown etiology which can result in wide range of systemic, neurologic and ophthalmic complications. It predominantly occurs in older people and may be associated with Polymyalgia Rheumatica. It must be treated urgently as it is associated with significant risk of permanent visual loss, stroke, aneurysm and possible death. Diagnosis of GCA can be based on clinical findings such as headache, scalp tenderness, jaw claudication and temporal artery problems, an elevated ESR and biopsy temporal artery showing typical histopathological findings. Diagnosis of GCA may be delayed when presentation is atypical.

Objectives: We report a case of an elderly lady presenting with scalp lump as an unusual presentation of GCA.

Methods: 70 years old lady presented with multiple painful scalp lumps to the surgeon was referred to the Rheumatologist when the excision biopsy of the lump diagnosed the GCA. (Sub cutis medium sized artery with severe arteritis composed with lymphocytes, neutrophils and occasional Eosinophils). On enquiry she revealed a history of generalized malaise and lethargy at the outset of the illness preceded by jaw pain. She had been initially referred to the dental surgeon which resulted in multiple carious tooth extractions without a relief. She didn't have any eye symptoms or headache at the outset. She lately developed headache and pain on touching the lumps.

On examination she had bilateral hardened thickened palpable non pulsatile temporal arteries. Her scalp was tender with multiple small cystic lumps. Her ESR was highly elevated 141mm/hr. WBC 9.7, Hb 9.5 and PLT 283. Her ANA, liver and renal profiles were normal. Her BL Doppler USS was consistent with BL temporal arteritis.

Results: She was soon started on high dose prednisolone with low dose aspirin which improved her systemic symptoms along with inflammatory markers significantly over a few days. She was referred for eye assessment and the involvement of other systemic larger arteries was ruled out.

Conclusion: Most of the cases the diagnosis of GCA is obvious but in patients with uncommon clinical presentation the diagnosis may be difficult. GCA is classified as disease of large vessel vasculitis but typically also involves medium and small arteries. The granulomatous inflammation in the vessel wall leads to obstruction of the lumen and ischemia in the territory distal to it. GCA involves almost all speciality and it is associated with increased morbidity and mortality if not diagnosed and treated early. Awareness of rare presentation of GCA avoids unnecessary investigation and delaying the treatment. If there is no rapid improvement of symptoms within few weeks of starting treatment other diagnosis should be considered.