arteritis who were considered clinically active or had increased CRP. However, the scores were lower compared to the original scoring performed at two hours. Therefore, whether one hour investigations have sufficient discriminatory value requires further studies.

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Figure 1

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AB0598

OSTEOPOROSIS AND RISK OF GIANT CELL ARTERITIS: A COMPARATIVE STUDY

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Background: Giant cell arteritis (GCA) and osteoporosis (OP) share many epidemiological features, such as occurrence in people >50 years old and increased incidence in women and northern Europe. Some known risk factors of OP, such as early menopause, nulliparity, low body mass index (BMI) and smoking, have also been linked to increased risk of GCA.

Objectives: We performed this study to investigate a potential link between OP and GCA onset by screening for OP by computed tomography (CT).

Methods: We retrospectively analyzed consecutive patients who underwent temporal artery biopsy (TAB) for suspected GCA in 4 hospitals. Cases and controls were defined by TAB-proven GCA and non-GCA diagnosis, respectively. Selection criteria additionally included 18F-FDG PET/CT at ± 30 days (GCA cases) or ± 90 days from the date of TAB (non-GCA controls). A radiologist blinded to patients' case or control status used CT images to measure the mineral density of trabecular bone in the first lumbar vertebra of all patients. OP was defined by previously identified thresholds of ≤ 110 Hounsfield units (HU) or ≤ 135 HU (1). We compared cases and controls for proportion of OP for the entire population and by sex. Statistical analyses involved chi-square and Student t tests for categorical and continuous variables, respectively.

Results: We included 50 cases and 59 controls. The most common diagnoses for controls were neurological disorders (n=21), autoimmune diseases (n=8), infections (n=10) and lack of an identifiable acute disease (n=9). Main demographic characteristics, prior cardiovascular and OP risk factors, and laboratory results are in the Table. Cases and controls did not differ in proportion with OP in the overall population (46% vs 49% [≤ 110 HU] and 60% vs 69% [≤ 135 HU]) or by sex (Table).

Conclusion: This study confirms that OP risk factors, that is, low BMI and nulliparity, are overrepresented in GCA, but our data do not suggest higher OP frequency in patients with new-onset GCA than controls. The

high absolute proportion of OP in patients with new-onset GCA deserves further investigation because it may have practical implications in these patients at risk of glucocorticoid-induced bone loss.

	GCA cases n=50	Controls n=59	P
Age at TAB, mean (SD)	72.6 (8.3)	70.4 (10.6)	0.227
Women, n (%)	30 (60)	35 (59)	1
Ever smoking, n (%)	22/47 (47)	20/50 (40)	0.499
Nulliparous women, n (%)	10/27 (37)	3/30 (10)	0.015
Body mass index, mean (SD)	24.0 (3.5) [47]*	25.9 (4.9) [51]*	0.030
History, n (%)			
Diabetes	6 (12)	18/58 (31)	0.020
Hypertension	31 (62)	44/58 (76)	0.119
OP fractures or OP treatment	3/42 (7)	7/59 (12)	0.516
Hypercholesterolemia	9/49 (18)	21/58 (36)	0.041
CRP (mg/l) at TAB, mean (SD)	96.9 (58.3) [47]*	45.9 (68.2) [59]*	<0.0001
Hb level (g/dl) at TAB, mean (SD)	11.5 (1.7) [44]*	12.2 (2.1) [59]*	0.048
OP (≤ 110 HU) at TAB, n (%)			
All	23 (46)	29 (49)	0.743
Women	17/30 (57)	20/35 (57)	0.970
Men	6/20 (30)	9/24 (38)	0.601
OP (≤ 135 HU) at TAB, n (%)			
All	30 (60)	41 (69)	0.300
Women	21/30 (70)	27/35 (77)	0.514
Men	9/20 (45)	14/24 (58)	0.378

*No. of patients with available data.

GCA: giant cell arteritis; TAB: temporal artery biopsy; OP: osteoporosis; CRP: C-reactive protein level; Hb: hemoglobin level

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AB0599

CLINICAL MANIFESTATIONS OF BEHÇET'S SYNDROME IN A LARGE COHORT OF ITALIAN PATIENTS: FOCUS ON GENDER DIFFERENCES

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Background: Behçet's syndrome (BS) is a chronic multisystemic inflammatory disorder classified among primary vasculitis. BS clinical hallmarks are mucocutaneous manifestations which include oral aphthosis (OA), genital ulcers (GU) and a wide spectrum of skin lesions. Other BS features include ocular inflammation, articular, gastrointestinal, vascular and neurological involvement. Some evidences suggest that in non endemic regions the disease tend to be less severe and women seem to be more commonly affected [1-3].

Objectives: The aim of this study was to investigate the clinical phenotypes of Italian BS patients with respect to gender and HLA-B51 status.

Methods: We retrospectively evaluated 324 Italian patients (185 males and 139 females), seen consecutively at Rheumatology Institute of Lucania (IReL) from 1st January 2000 to 31st December 2017. Demographics, clinical features during follow-up and HLA status were obtained from a review of medical records. The analysis was limited to patients fulfilling the ISG criteria.

Results: 324 BS patients were identified in our database. 39 (17 males and 22 females) were excluded because did not satisfied ISG criteria and 285 (168 males and 117 females) resulted eligible for the present study. Results are summarized in table 1. We found statistically significant differences in papulopustular lesions, posterior uveitis and deep venous thrombosis (DVT), which occur more frequently in males compared with females (83.3% versus 46.2%, 37% versus 18.8% and 8.3% versus 0.9% respectively; $p < 0.01$). Erythema nodosum (EN) (59% versus 41.1%, $p < 0.01$), arthralgia (52.1% versus 31.5%, $p < 0.01$) and intestinal involvement (11.3% vs 21.4% $p < 0.05$) resulted more frequent in females compared with males. No differences were found in HLA status (M 67.9% vs F 61.5%).