articulars 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.

REFERENCES


AB0598 OSTEOPOROSIS AND RISK OF GIANT CELL ARTERITIS: A COMPARATIVE STUDY

PEN DU Claire 1*, Patrick TCHOUANTE2, Kim LY2, Jean-François ALEXANDRA3, Natalla ASLANBEKOVA2, Khadjia BENALI3, Solange GONZALEZ-ChAPIPE2, Sarah LECHTMAN4, Damien SENE5, Cornelia WEYAND6, Karim SACRE7, Alfred MAHR8.

1Saint-Louis University Hospital, PARIS, France; 2Limoges University Hospital, Limoges, France; 3Bichat University Hospital, PARIS, France; 4Lariboisière University Hospital, PARIS, France; 5Stanford University, PALO ALTO, United States of America

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. 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.

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 for the entire population (41.1% vs 46%, p=0.19) or by sex (43.8% vs 47.2%, p=0.53).

Conclusions: 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.

REFERENCE


Disclosure of Interests: Claire LE PENDU: None declared, Patrick TCHOUANTE: None declared, Kim LY: None declared, Jean-François ALEXANDRA: None declared, Natella ASLANBEKOVA: None declared, Khadjia BENALI: None declared, Solange GONZALEZ-ChAPIPE: None declared, Sarah LECHTMAN: None declared, Damien SENE: None declared, Cornelia WEYAND: None declared, Karim SACRE Grant/research support from: GSK, Alfred MAHR Consultant for: Chugai Pharma France, Speakers bureau: Roche SAS Chugai Pharma France DOI: 10.1136/annrheumdis-2019-eular.2388

AB0599 CLINICAL MANIFESTATIONS OF BEHÇET’S SYNDROME IN A LARGE COHORT OF ITALIAN PATIENTS: FOCUS ON GENDER DIFFERENCES

Pietro Lecce1*, Nancy Lascaro1, Maria Carmela Padula1, Teresa Carbone1, Angela Padula1, Salvatore D’Angelo1,2,3,4,5 Rheumatology Institute of Lucania (IReL), San Carlo Hospital, Potenza, Italy; 2Basilea Ricerca Biomedica (BRB), Foundation, Potenza, Italy

Background: Behçet’s syndrome (BS) is a chronic multisystem 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 31th December 2017. Demographic, 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 satisfy 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%, p<0.001), 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%).
Conclusions: In our cohort of Italian BS patients the disease results slightly more prevalent in males. Gender-related differences were observed for posterior uveitis, DVP and papulopustular lesions which are more frequent in males, whereas EN-like lesions, arthralgia and involvement are more frequently observed in females. These data confirm that BS tend to be less aggressive in Italian female patients. No sex-differences were observed in HLA-B51 status.

Table 1. Clinical manifestations of male and female BS patients

<table>
<thead>
<tr>
<th>Clinical Manifestations</th>
<th>Male (148)</th>
<th>Female (117)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>32 (22.2)</td>
<td>23 (25.9)</td>
</tr>
<tr>
<td>Genital</td>
<td>63 (42.6)</td>
<td>49 (49.6)</td>
</tr>
<tr>
<td>Polyarthropathy</td>
<td>34 (23.1)</td>
<td>25 (21.6)</td>
</tr>
<tr>
<td>Neuropathic symptoms</td>
<td>3 (2.0)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Episcleritis</td>
<td>4 (2.7)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Arthritis</td>
<td>36 (24.4)</td>
<td>30 (25.7)</td>
</tr>
<tr>
<td>Deep venous thrombosis</td>
<td>22 (15.0)</td>
<td>13 (11.1)</td>
</tr>
<tr>
<td>Papulopustular lesions</td>
<td>27 (18.3)</td>
<td>26 (22.5)</td>
</tr>
<tr>
<td>Mucocutaneous lesions</td>
<td>54 (37.0)</td>
<td>44 (38.0)</td>
</tr>
<tr>
<td>DVP</td>
<td>14 (9.8)</td>
<td>11 (9.5)</td>
</tr>
<tr>
<td>Posterior uveitis</td>
<td>13 (9.5)</td>
<td>10 (8.7)</td>
</tr>
<tr>
<td>Genital ulcers</td>
<td>10 (7.0)</td>
<td>12 (10.4)</td>
</tr>
<tr>
<td>Oral ulcers</td>
<td>20 (13.9)</td>
<td>24 (20.7)</td>
</tr>
<tr>
<td>Other extraoral lesions</td>
<td>29 (20.1)</td>
<td>27 (23.2)</td>
</tr>
</tbody>
</table>

Abbreviations: n, number of subjects; OR, odds ratio; CI, confidence interval statistically significant, *p<0.05, **p<0.01

Methods: We retrospectively evaluated BD patients according to ICBD (2) and/or ISG (3) criteria who had undergone apremilast therapy (30 mg twice daily) for oral and/or genital ulcers from November 2017 to January 2018 in four different specialized referral units in Italy (Bari, Firenze, Potenza, Siena). Retrieved data including previous treatments were also collected. Our endpoint was to assess the number of oral and genital ulcers under apremilast treatment. Moreover pain due to ulcers was evaluated with a 100-mm visual-analogue scale (VAS), whereas disease activity was assessed by means of BDCF score. Paired t-test or Wilcoxon matched-pair signed rank test, if applicable, were used for statistical analysis.

REFERENCES


Disclosure of Interests: Giuseppe Lopalco Speakers bureau: SOBI, BMS, vencino venenato: None declared, Pietro Lecceese: None declared, Giacomo Emmi: None declared, Luca Cantarini: None declared, Nancy Lascaro: None declared, Gerardo Di Scala: None declared, Stefano Gentilisci: None declared, Anna Abbruzzese: None declared, Marco Forinaro: None declared, Fabio Cacciapaglia: None declared, Giovanni Lapadula: None declared, Florenzo Iannone Consultant for: F Iannone has received consultancy fees and/or speaker honoraria from Pfizer, AbbVie, MSD, BMS, Novartis, Lilly, UCB outside this work, Speakers bureau: F Iannone has received consultancy fees and/or speaker honoraria from Pfizer, AbbVie, MSD, BMS, Novartis, Lilly, UCB outside this work.

Figure 1

Figure 2

Results: Thirteen patients (9 females, 69.2%) with disease duration (mean ±SD) of 154.2 ± 167.7 months underwent apremilast treatment because of oral and genital ulcers inadequately responsive to previous immunosuppressant and/or biologic agents. At baseline, patients complained of 1 (1-1) median (IQR) oral and 0 (0-1) genital ulcers. At 3-month follow-up (data collected for 12/13 patients) the median number was 0 (0-1) for oral ulcers, and 0 (0-0) for genital ones, showing a significant improvement (p<0.05 for both). However, after 6 months, 3/12 patients (25%) stopped the treatment due to diarrhea. Thereafter, at 6-month follow-up, a significant improvement of oral ulcers was observed (data collected for 8/13 patients, p=0.03), whereas a statistical significance for genital ulcers was not reached, even in the presence of a positive trend (p=0.07). A notable reduction in VAS and BDCF scores was observed either after 3 months (p=0.004 and p=0.02, respectively) and 6 months (p<0.01 and p=0.02, respectively). The mean number of relapsing oral and genital ulcers during the first 3 months of therapy was significantly lower than that observed in the four weeks prior to apremilast (p<0.01 for both). Similarly, the average number of the sole oral ulcers appreciably decreased in the first 6 months of therapy (p=0.03). Notably no infections were reported during the whole observation period.

Conclusion: Our results, despite the small sample size, corroborate apremilast employment in real-life settings as viable treatment option in BD patients with mucosal involvement multi-refractory to standard treatments.

REFERENCES

