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.

REFERENCES

- [1] - Grayson PC, Alehashemi S, Bagheri AA, et al. 18 F-Fluorodeoxyglucose-Positron Emission Tomography As an Imaging Biomarker in a Prospective, Longitudinal Cohort of Patients With Large Vessel Vasculitis. *Arthritis Rheumatol.* 2018;70:439-449.
- [2] - Dejaco C, Ramiro S, Duftner C, et al. EULAR recommendations for the use of imaging in large vessel vasculitis in clinical practice. *Ann Rheum Dis.* 2018;77:636-643.

Figure 1

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.6843

AB0598

OSTEOPOROSIS AND RISK OF GIANT CELL ARTERITIS: A COMPARATIVE STUDY

PENDU Claire LE¹, Patrick Tchouante¹, Kim Ly², Jean-François Alexandra³, Natella Aslanbekova², Khadija Benali³, Solange Gonzalez-Chiappe¹, Sarah Lechtman⁴, Damien Sene⁴, Cornelia Weyand⁵, Karim Sacre³, Alfred Mahr¹.
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. 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

REFERENCE

- [1] Pickhardt PJ et coll. Opportunistic screening for osteoporosis using abdominal computed tomography scans obtained for other indications. *Ann Intern Med.* 2013 16;158:588-95.

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, Khadija Benali: None declared, Solange GONZALEZ-CHIAPPE: 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 Leccese¹, Nancy Lascaro¹, Maria Carmela Padula¹, Teresa Carbone¹, Angela Padula¹, Salvatore D'angelo^{1,2}. ¹Rheumatology Institute of Lucania (IReL), San Carlo Hospital, Potenza, Italy; ²Basilicata Ricerca Biomedica (BRB) Foundation, Potenza, Italy

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%).

Conclusion: 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 intestinal 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

Clinical Manifestations	Overall (285) n(%)	Male (168) n(%)	Female (117) n(%)	OR (95%CI)	p-value
OA	285 (100.0)	168 (100.0)	117 (100.0)	1.44 (0.00-9231)	NS
GU	171 (60.0)	95 (56.5)	76 (65.0)	0.70 (0.43-1.14)	NS
EN	138 (48.4)	69 (41.1)	69 (59.0)	0.48 (0.30-0.78)	0.0029**
Folliculitis	50 (17.5)	32 (19.0)	18 (15.3)	1.29 (0.69-2.44)	NS
Papulopustular lesions	194 (68.1)	140 (83.3)	54 (46.2)	5.83 (3.38-10.06)	0.0000**
Pathergy test	20 (45.5)	12 (7.1)	8 (6.8)	1.05 (0.41-2.65)	NS
Posterior uveitis	84 (29.5)	62 (37.0)	22 (18.8)	2.53 (1.44-4.42)	0.0010**
Anterior uveitis	51 (17.9)	29 (17.3)	22 (18.8)	0.90 (0.49-1.66)	NS
Panuveitis	24 (8.4)	17 (10.1)	7 (6.0)	1.77 (0.71-4.41)	NS
Episcleritis	4 (1.4)	2 (1.2)	2 (1.7)	0.69 (0.10-4.49)	NS
Arthralgia	114 (40.0)	53 (31.5)	61 (52.1)	0.42 (0.26-0.69)	0.0005**
Arthritis	74 (26.0)	44 (26.2)	30 (25.6)	1.03 (0.60-1.76)	NS
Deep venous thrombosis (DVT)	15 (5.3)	14 (8.3)	1 (0.9)	10.55 (1.37-81.35)	0.0054**
Superficial venous thrombosis (SVT)	33 (11.6)	18 (10.7)	15 (12.8)	0.82 (0.39-1.69)	NS
Neurological involvement	70 (24.6)	36 (21.4)	34 (29.1)	0.67 (0.39-1.15)	NS
Fatigue	72 (25.3)	37 (22.0)	35 (29.9)	0.66 (0.39-1.13)	NS
Fever	119 (41.8)	76 (45.2)	43 (36.8)	1.42 (0.88-2.31)	NS
Intestinal involvement	44 (15.4)	19 (11.3)	25 (21.4)	0.47 (0.24-0.90)	0.0208*
HLA-B51 positivity	186 (65.3)	114 (67.9)	72 (61.5)	1.32 (0.81-2.16)	NS

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

Figure 1

REFERENCE

- [1] Leccese P, et al. *Curr Opin Rheumatol*.2017;29(1):12-16. [2] Hatemi G, et al. *Clin Exp Rheumatology*.2016;34 Suppl 102:10-22. [3] Pipitone N, et al. *Clin Exp Rheumatol*.2004;22(6 Suppl 36):S46-51.

Acknowledgement: Many thank to Professor Olivieri for his teachings

Disclosure of Interests: Pietro Leccese: None declared, Nancy Lascaro: None declared, Maria Carmela Padula: None declared, Teresa Carbone: None declared, Angela Padula Speakers bureau: Lilly Italia EMS, Salvatore D'Angelo: None declared

DOI: 10.1136/annrheumdis-2019-eular.4711

AB0600

APREMILAST EFFECTIVENESS IN REFRACTORY ORAL AND GENITAL ULCERS OF BEHÇET'S DISEASE: DATA FROM REAL LIFE SETTINGS

Giuseppe Lopalco¹, Vincenzo Venerito¹, Pietro Leccese², Giacomo Emmi³, Luca Cantarini⁴, Nancy Lascaro², Gerardo Di Scala³, Stefano Gentileschi⁴, Anna Abbruzzese¹, Marco Fornaro¹, Fabio Cacciapaglia¹, Giovanni Lapadula¹, Florenzo Iannone¹. ¹University of Bari, Bari, Italy; ²Rheumatology Institute of Lucania, Potenza, Italy; ³University of Florence, Firenze, Italy; ⁴University of Siena, Siena, Italy

Background: Mucocutaneous lesions represent the earliest and the most frequent manifestations of Behçet's disease (BD), and may become disabling leading to substantial effect on quality of life. Recently the efficacy of the small molecule inhibitor of phosphodiesterase 4 apremilast in treating oral and genital ulcers has been shown in a phase 2 trial (1), whereas to date no results from real world data are available.

Objectives: The purpose of the present study was to describe our experience with apremilast in treating BD patients with oral and genital ulcers refractory to traditional therapies and previous biologic agents in real life settings

Figure 1

Methods: We retrospectively evaluated BD patients according to ICB (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 BDCAF score. Paired t-test or Wilcoxon matched-pair signed rank test, if applicable, were used for statistical analysis.

Figure 2

Results: Thirteen patients (9 females, 69.2%) with disease duration (mean $\pm$ 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 ($p=0.02$ for both). However, after 3 months, 3/12 patients (25%) stopped the treatment due to diarrhoea. 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 BDCAF 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

- [1] Hatemi G, Melikoglu M, Tunc R, Korkmaz C, Turgut Ozturk B, Mat C, et al. Apremilast for behcet's syndrome-a phase 2, placebo-controlled study. *N Engl J Med* 2015;372:1510-8.
[2] International Team for the Revision of the International Criteria for Behçet's D. The international criteria for behcet's disease (icbd): A collaborative study of 27 countries on the sensitivity and specificity of the new criteria. *J Eur Acad Dermatol Venereol* 2014;28:338-47.
[3] O'Neill TW, Rigby AS, Silman AJ, Barnes C. Validation of the international study group criteria for behcet's disease. *Br J Rheumatol* 1994;33:115-7.

Disclosure of Interests: Giuseppe Lopalco Speakers bureau: SOBI, BMS, Vincenzo Venerito: None declared, Pietro Leccese: None declared, Giacomo Emmi: None declared, Luca Cantarini: None declared, Nancy Lascaro: None declared, Gerardo Di Scala: None declared, Stefano Gentileschi: None declared, Anna Abbruzzese: None declared, Marco Fornaro: 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

DOI: 10.1136/annrheumdis-2019-eular.4290