the grant has been closed., Sue Ashdown: None declared, Peter Cronholm: None declared, Raashid Luqmani Grant/research support from: Roche, Vifor and GSK, Peter Merkel: None declared, Nataliya Milman: None declared, Jacqueline Peck: None declared, Joanna Robson: None declared

DOI: 10.1136/annrheumdis-2019-eular.7135

AB0608 TOCILIZUMAB TREATMENT FOR LARGE VESSELS VASCULITIS: REAL LIFE PRELIMINARY EXPERIENCES

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Background: IL-6 α targeting therapy has been proven to be effective and safe in Giant Cell Arteritis (GCA) as well in Takayasu Arteritis (TA) in RCTs, probably because of the similar pathologic findings and vessel size (Large Vessel Vasculitis, LVV). However, real world data are scarce. **Objectives:** The aim of the study was to evaluate the effectiveness of Tocilizumab for LVV in real life settings.

Methods: We retrospectively evaluated, from 2011 to 2017, the outcomes (including glucocorticoid dosage) in patients affected by LVV (according to 1990 ACR classification criteria) who received 8 mg/kg iv Tocilizumab (TCZ) monthly, due to the inadequate response to immunosuppressant. Demographic and clinical characteristics and laboratory findings were collected at baseline and consecutive follow up visits, over 52 weeks. Statistical analysis was performed using the GraphPad Software ver. 6.0 (San Diego CA USA) using appropriate tests.

Results: We analyzed n.10 patients (6/10 GCA, 4/10 TA) with mean age ($\pm$ SD) 56 $\pm$ 21 years and mean disease duration 41 $\pm$ 38 months. Eight out of 10 patients were female. Over the entire observation period, 7/10 also received concomitant methotrexate (mean dose 12.8 $\pm$ 2.7 mg/week) while 2/10 received azathioprine (100 mg/day). Median (IQR) prednisone equivalent dose at baseline was 22.5 (10-25) mg/day. At baseline, median ESR was 49 (31-58) mm/h and median CRP level was 15.4 (1.95-28.53) mg/l. Upon TCZ treatment we observed a good disease control in absence of headache, fever and other LVV clinical signs through 52-week follow up. At 52 weeks, we observed a significant reduction of ESR down to 6.5 (2.75-12.25) mm/h as well as of CRP level, down to 1.5 (0.67-3.47) mg/l (p <0.001). A meaningful steroid sparing effect was also achieved as a significant reduction in prednisone dose down to 5 (1.87-6.25) mg/day (p <0.001). During the 52-week follow up period, 3 patients discontinued TCZ treatment for side effects: 1 for severe neutropenia (at 12 weeks), 1 for hemorrhagic pancreatitis (after 24 weeks), and 1 for diverticulitis (after 52 weeks).

Conclusion: In our real life experience iv TCZ was effective and safe in LVV treatment, with a good disease control and a significant steroid-sparing effect. Our preliminary findings need to be confirmed in larger cohorts and prolonged follow-up.

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Disclosure of Interests: giulia righetti: None declared, vincenzo venerito: None declared, maria giannotta: None declared, giuseppe lopalco: Speakers bureau: SOBI, BMS, margherita giannini: None declared, fabio cacciapaglia: None declared, laura coladonato: 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.2395

AB0609 NAILFOLD VIDEO CAPILLAROSCOPY AS A POTENTIAL DIAGNOSTIC TOOL IN SYSTEMIC VASCULITIS

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Background: Vasculitides are formally classified by artery size: large, medium or small, yet some overlap is evident as in Takayasu, a large vessel vasculitis manifesting also in retinal arterioles. Nailfold videocapillaroscopy (NVC) enables us to inspect changes in microvasculature. Only several small uncontrolled case series of light capillary microscopy in adult patients with vasculitis were reported in the literature, describing avascular areas and microhemorrhages in granulomatosis with polyangiitis (GPA) patients [1-2] and in [4] Behcet disease, and thin and tortuous capillaries in Takayasu arteritis [5].

Objectives: To characterize nailfold capillary changes by NVC in patients with autoimmune vasculitis compared to healthy controls.

Methods: Consecutive autoimmune vasculitis patients fulfilling the ACR criteria and age and gender matched healthy controls were evaluated by NVC using Optilia Mediscope with a magnification of X200. Patients with peripheral artery disease and ischemic heart disease were excluded. Capillaroscopy images were centrally analyzed. NVC was analyzed, noting: architecture, number of capillaries per field, capillary width, capillary morphology, microhemorrhages, peri-capillary stippling (PCS)- hemosiderin deposits probably representing former capillary leak, slow capillary flow ("rolling" or sludging of red blood cells) and avascularity. Continuous data are presented as the mean $\pm$ SD. Categorical variables are presented as frequencies and percentages. Comparisons of continuous variables were made using 2-tailed t-tests and differences between groups by a 1-Way ANOVA.

Results: Seventeen patients with active vasculitis, 8 patients with vasculitis in remission (11 polyarteritis nodosa, 2 GPA, 3 eosinophilic granulomatosis with polyangiitis, 2 microscopic polyangiitis, 2 Takayasu, 3 Sjogren vasculitis (one with cryoglobulinemia), 1 primary central nervous system vasculitis and 1 lupus vasculitis) were compared to 25 age and sex matched healthy controls. The mean age (59 $\pm$ 18 vs. 51 $\pm$ 19 vs. 52 $\pm$ 15), and the percent of females (53%, 50%, 60%), were similar between the groups.

Patients with active vasculitis demonstrated higher rate of "rolling", 74.1% $\pm$ 27 vs. 12.5% $\pm$ 22 vs. 6.5% $\pm$ 12.7, p <0.001; microhemorrhages or PCS 30.1% $\pm$ 26.4 vs. 1.5% $\pm$ 4.5 vs. 1.9% $\pm$ 1, p <0.05, which reversely correlated with disease duration r =-0.4, P =0.05; avascular areas 76% $\pm$ 19.5 vs. 23.4% $\pm$ 28 vs. 26% $\pm$ 18.5, p <0.01 and neoangiogenesis 57% $\pm$ 23% vs 26.5% $\pm$ 22.5 vs. 6% $\pm$ 10.5, p <0.01. PCS was observed exclusively in 5 of 17 patients with active vasculitis.

Conclusion: Patients with active vasculitis demonstrate capillary abnormalities, namely: "rolling", microhemorrhages, avascular areas and neoangiogenesis. PCS may be a specific sign of active vasculitis. NVC is an easy, readily available additive tool in the management of vasculitis. Further studies are needed to ascertain the role of NVC in vasculitis.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.2197