and d) transmural inflammation (TMI). The presence of giant cells, thrombosis and dystrophic calcification was also noted.

Results: We included a total of 24 patients with positive TAB: a) 19 patients (79.16%) presented TMI and b) 5 patients (20.84%) presented ILA. There were no cases with SVV or VVV.

No significant differences at baseline were observed between the 2 groups regarding sex and age, with a mean of 79.6 ± 7.2 years in TMI group and 78.8 ± 7.3 years in ILA group ($p = 0.83$).

There were no significant differences between the correlation of the clinical and analytical data and the 2 patterns of inflammation observed in the biopsy (**TABLE-1**).

Regarding the treatment at the time of performing the BAT, 16 (of 19) patients in the group with TMI (84.2%) and 4 (of 5) patients in the group with ILA (80%) were receiving treatment with oral glucocorticoid (Prednisone). No significant differences between the two groups were found in terms of treatment duration prior to BAT and nor in the dose received (**TABLE-2**).

Conclusion: In our sample, we didn't observe differences between the patterns of inflammation and the analytical and clinical data. It is important to recognise these patterns of inflammation in the TAB to avoid false negatives.

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TABLE-1. CLINICAL AND ANALYTICAL DATA.

Variables	TMI (n=19)	ILA (n=5)	P
Sex (women), n (%)	10 (52.6)	5 (100.0)	0.12
Age at disease onset, (mean $\pm$ SD)	79.6 ± 7.2	78.8 ± 7.3	0.83
CLINICAL DATA			
Any cranial symptoms	17 (89.5)	3 (60.0)	0.18
Headache	15 (78.9)	3 (60.0)	0.57
Scalp Tenderness	6 (31.6)	2 (40.0)	0.99
Abnormalities of temporal arteries	9 (47.4)	1 (20.0)	0.36
Jaw claudication	9 (47.4)	2 (40.0)	0.99
Visual loss	5 (23.8)	1 (20.0)	0.99
Any visual symptoms	15 (78.9)	3 (60.0)	0.62
Systemic signs/symptoms	11 (57.9)	4 (80.0)	0.51
PMR	5 (26.3)	3 (60.0)	0.29
Peripheral synovitis	0 (0.0)	0 (0.0)	0.99
ANALYTICAL DATA			
ESR (mean $\pm$ SD) (mm/H)	64.2 ± 36.7	74.0 ± 32.2	0.57
CRP (mean $\pm$ SD) (mg/dL)	10.2 ± 9.0	9.5 ± 8.8	0.75
Hemoglobin (mean $\pm$ SD) (g/dL)	11.6 ± 1.5	11.1 ± 2.4	0.43

TABLE-2. TREATMENT.

Variables	TMI (n=19)	ILA (n=5)	P
TREATMENT			
Patients taking Prednisone at the time of TAB	16 (84.2)	4 (80.0)	0.99
Prednisone dose at the time of TAB (median [IQR]) (mg/d)	40.0 [30.0-60.0]	270.0 [23.0-875.0]	0.44
Duration of Prednisone treatment before TAB (median [IQR]), days	5.0 [1.0-8.0]	3.0 [1.0-30.0]	0.90

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AB0613

PRESENTATION OF TAKAYASU ARTERITIS ACCORDING TO THE AGE OF ONSET IN A MONOCENTRIC ITALIAN COHORT

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Background: Takayasu arteritis (TA) is a large-vessel vasculitis usually affecting young women. The age of onset is though variable. Controversial data are reported about differences in disease features according to the age of onset.

Objectives: To compare clinical and vascular TA features according to TA age of onset.

Methods: We retrospectively evaluated onset demographic and disease features in TA patients followed-up at our Hospital between January 2000 and August 2018. We divided our cohort into 3 groups according to the age of onset: ≤ 20 (Group 1), 21-40 (Group 2), > 40 (Group 3) years. Diagnostic delay (DD) was defined as the time interval between the first TA symptom and TA diagnosis. Non parametric statistic tests were used.

Results: 126 patients (12 male, 114 female) were analyzed. Mean age at onset was 31.46 ± 13.38 years. Group 1 and 3 included 30 (23.81%) patients each, Group 2 66 (52.38%). Mean age at onset was 16.23 ± 3.20 years in Group 1, 29.59 ± 5.80 in Group 2 and 50.8 ± 7.16 in Group 3. Mean DD was different between the 3 groups: 117.63 ± 129.79 months in Group 1, 56.47 ± 76.98 in Group 2 and 30.80 ± 40.53 in Group 3 (Group 1 vs 2, $p=0.021$; Group 1 vs 3, $p<0.001$; Group 2 vs 3, $p=0.089$). Clinical and laboratory features at TA onset are summarized in Table 1. Among all disease features only arterial hypertension was statistically more prevalent in Group 3 vs Group 1 and 2 (56.67% vs 36.67% and 30.30% respectively, $p=0.048$). When evaluating vascular involvement, abdominal aorta was more frequently affected in Group 1 (63.33% vs 34.85% and 56.67%, $p=0.018$) while right iliac and left iliac arteries in Group 3 (40% vs 23.33% and 10.61%, $p=0.004$; 36.67% vs 23.33% and 12.12%, $p=0.024$ respectively).

Abstract AB0613 Table 1

Clinical and laboratory features	Group 1 n 30 (%)	Group 2 n 66 (%)	Group 3 n 30 (%)	p-value
Systemic symptoms	21 (70)	37 (56.06)	15 (50)	0.254
Carotidynia	11 (36.67)	12 (18.18)	5 (16.67)	0.116
Lower extremities claudication	7 (23.33)	18 (27.27)	4 (13.33)	0.363
Upper extremities claudication	10 (33.33)	31 (46.97)	7 (23.33)	0.083
Δ blood pressure	10 (33.33)	16 (24.24)	6 (20)	0.526
Reduced/absent pulse	18 (60)	29 (43.94)	11 (36.67)	0.178
Bruits	15 (50)	20 (30.30)	8 (26.67)	0.114
Angina abdominis	6 (20)	6 (9.09)	3 (10)	0.376
Myocardial infarction	0	5 (7.58)	4 (13.33)	0.154
Heart failure	0	6 (9.09)	0	0.078
Arterial hypertension	11 (36.67)	20 (30.30)	17 (56.67)	0.048*
Headache	10 (33.33)	9 (13.64)	8 (26.67)	0.067
Syncope	9 (30)	9 (13.64)	6 (20)	0.180
Stroke	2 (6.67)	6 (9.09)	2 (6.67)	1
Amaurosis	4 (13.33)	4 (6.06)	3 (10)	0.499
$\uparrow$ inflammatory markers	25 (83.33)	52 (78.79)	25 (83.33)	0.869
Vascular surgery	8 (26.67)	13 (19.70)	11 (36.67)	0.202

Abstract AB0613 Table 2

Artery	Group 1 n 30 (%)	Group 2 n 66 (%)	Group 3 n 30 (%)	p-value
Coronary	2 (6.67)	7 (10.61)	4 (13.33)	0.274
Pulmonary	5 (16.67)	12 (18.18)	1 (3.33)	0.146
R subclavian	14 (46.67)	32 (48.48)	17 (56.67)	0.771
L subclavian	18 (60)	43 (65.15)	22 (73.33)	0.554
R CC	19 (63.33)	36 (54.55)	18 (60)	0.701
L CC	21 (70)	38 (57.58)	19 (63.33)	0.497
R vertebral	3 (10)	11 (16.67)	3 (10)	0.648
L vertebral	4 (13.33)	12 (18.18)	6 (20)	0.863
Brachiocephalic	10 (33.33)	22 (33.33)	6 (20)	0.425
Ascending ao	11 (36.67)	19 (28.79)	6 (20)	0.369
Arch	9 (30)	20 (30.30)	11 (36.67)	0.821
Descending ao	10 (33.33)	17 (25.76)	9 (30)	0.756
Abdominal ao	19 (63.33)	23 (34.85)	17 (56.67)	0.018*
Celiac	7 (23.33)	23 (34.85)	12 (40)	0.344
Superior mesenteric	8 (26.67)	22 (33.33)	6 (20)	0.398
R renal	9 (30)	16 (24.24)	4 (13.33)	0.297
L renal	7 (23.33)	15 (22.73)	5 (16.67)	0.843
R iliac	7 (23.33)	7 (10.61)	12 (40)	0.004*
L iliac	7 (23.33)	8 (12.12)	11 (36.67)	0.024*

Abbreviations: right (R), left (L), common carotid (CC), aorta (ao)

Conclusion: TA patients <20 years might experience a longer DD. Arterial hypertension seems to be a prevalent feature in TA patients >40 years. Vascular involvement seems also to be influenced by the age of onset with the abdominal aorta being more frequently affected in younger patients and iliac arteries in older patients. **Disclosure of Interests:** Silvia Sartorelli: None declared, Corrado Campochiaro Consultant for: Dr Corrado Campochiaro received consultation honoraria from Pfizer., Alessandro Tomelleri: None declared, Elena Baldissera Consultant for: Consultation honoraria from Novartis and Rottapharm, Speakers bureau: Pfizer, Sobi, Novartis, Lorenzo Dagna Consultant for: Prof Lorenzo Dagna received consultation honoraria from Abbvie, Amgen, Biogen, Bristol-Myers Squibb, Celltrion, Novartis, Pfizer, Sanofi-Genzyme, and SOBI.
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AB0614 A SINGLE, SUCCESSFUL INFLIXIMAB INFUSION FOR BEHCET'S DISEASE ASSOCIATED SIGHT-THREATENING UVEITIS ATTACK, FOLLOWED BY 2 ADDITIONAL INFUSIONS, PRODUCE LONG TERM OCULAR REMISSION

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Background: Recommendations on the use of anti-TNF agents in Behcet's disease BD include the administration of a single infusion of infliximab, 5 mg/kg for bilateral posterior eye segment inflammation as a first-line agent to achieve a fast-onset response (Sfrikakis PP et al, Rheumatology 2007). On the other hand, long-term remission is feasible after discontinuation of successful anti-TNF treatment given for severe BD, including posterior ocular inflammation (Sfrikakis PP et al. Arthritis Rheumatol 2017).

Objectives: To report the long-term outcome of successful short-term Infliximab treatment for sight-threatening uveitis in Behcet's disease.

Methods: In this retrospective single-center analysis, we identified all patients with BD followed up in our center at least once yearly since 2001, who received one successful IV infusion of Infliximab (5mg/kg) for bilateral sight threatening posterior uveitis attack, followed by 2 additional infusions 2 months apart. Other severe BD manifestations at the time of attack included severe mucocutaneous disease (n=3), arthritis (n=2), vascular (n=1), and gastrointestinal involvement (n=1). The first Infliximab infusion was considered successful if complete suppression of acute ocular inflammation was achieved. Study's endpoint was the proportion of patients remaining in complete ocular remission for at least 5 years after cessation of Infliximab.

Results: We identified 10 patients (aged 52±14.3 years, 60% men, disease duration 12±5.2 years) who received 3 IV Infliximab infusions (5 mg/kg each) for sight-threatening posterior ocular inflammation (20 eyes), either at the first attack (n=5) or for relapsing attacks (n=5). Infliximab was given as add-on to azathioprine (n=7) or to azathioprine in combination with cyclosporine (n=2). Nine of ten patients (90%) achieved the study's endpoint, i.e. after cessation of short-term Infliximab treatment remain in complete ocular remission for a mean of 9.5±4.2 years (range 5-15.3 years). The last patient relapsed 6 months after Infliximab discontinuation, but subsequently responded to antiTNF re-treatment, which is continued to date. Notably, four of the nine patients who achieved the study's endpoint were also able to discontinue azathioprine and are currently any drug free.

Conclusion: The majority of patients with sight-threatening uveitis who responded completely to a first Infliximab infusion and received 2 additional infusions, remain in remission for many years thereafter. Additional studies to confirm that short term infliximab treatment with observation for objective improvement should be promptly administered in every BD patient with sight-threatening uveitis attack are warranted.

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AB0615 PREVALENCE OF DEPRESSION, ANXIETY, FATIGUE AND SLEEP DISTURBANCES IN PATIENTS OF RA, SLE AND GPA

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Background: The relative frequencies of co-morbidities like depression, anxiety, fatigue and sleep disturbance in RA, SLE and GPA are not fully elucidated.

Objectives: To estimate and correlate the prevalence of depression, anxiety, fatigue and sleep disturbances in patients with RA, SLE and GPA by using time honored scales and PROMIS-HAQ¹.

Methods: This was a cross sectional study of 183 patients (RA – 57, SLE – 64, GPA – 62). Diagnosis and assessment of depression, insomnia, anxiety and fatigue was established by patient health questionnaire 9 (PHQ 9), Epworth sleepiness scale (ESS), generalized anxiety disorder assessment scale 7 (GAD 7) and fatigue severity scale (FSS) respectively. PROMIS-HAQ short form 8a was also used to diagnose depression, insomnia, anxiety and fatigue and its correlation with the above time honored scales was studied.

Results: Mean age of RA, SLE and GPA patients was 45.5 ± 12, 31 ± 9.5 and 42.7 ± 13.5 years respectively. Mean disease duration was 5.7 ± 5.1, 3.3 ± 2.4 and 4.6 ± 4 years in RA, SLE and GPA respectively. Prevalence of depression, anxiety, fatigue, insomnia in RA, SLE and GPA as per standard scales and PROMIS HAQ is depicted in table 1. The correlation between the standard scales and PROMIS HAQ for depression [RA (r .816, p< .001), SLE (r .625, p< 0.001), GPA (r .0772, p <0.001)], anxiety [RA (r .804, P< .001), SLE (r .0709, p<0.001), GPA (0.888, p<0.001)], sleep disturbance [RA (r .872, p<0.001), SLE (r .0784, p< 0.001), GPA (r-0.917, p <0.001)] and fatigue [RA (r .815, p< .001), SLE (r .0798, p< 0.001), GPA (r-0.805, p <0.001)] was significant.

Table 1. Prevalence of depression, anxiety, fatigue and insomnia by various scales

	Depression		Anxiety		Fatigue		Sleep/Insomnia	
	PHQ9	PROMIS HAQ	GAD7	PROMIS HAQ	FSS	PROMIS HAQ	ESS	PROMIS HAQ
RA	49.2%	35.1%	45.6%	38.5%	40.4%	49.1%	19.3%	17.5%
SLE	60.9%	43.7%	51.6%	40.6%	51.6%	57.8%	15.6%	14.1%
GPA	46.8%	21%	29.0%	24.0%	38.7%	40.3%	16.1%	12.9%

Conclusion: Depression, anxiety, fatigue and sleep disturbance are common in RA, SLE and GPA. PROMIS HAQ has good correlation with time honoured scales for assessment of depression, anxiety, fatigue and sleep disturbance in these disorders.

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AB0616 HISPANIC AMERICAN PATIENTS WITH ANCA ASSOCIATED VASCULITIS AND DIFFUSE ALVEOLAR HEMORRHAGE RESPOND COMPARABLY TO INDUCTION THERAPY

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Background: Hispanic American patients with ANCA-associated vasculitis (AAV) have been reported to have more severe disease and higher