articles describing sex differences in TAK patients were obtained^{3,4,5}. A global analysis of these 3 cohorts plus ours (for a total of 578 patients, 108 men and 470 women) was performed.

Results: In our TAK cohort, age at disease onset and age at diagnosis were not significantly different between men and women. Diagnostic delay was slightly higher in men. Male patients showed higher involvement of iliac arteries (right, $p=0.016$; left, $p=0.021$); female patients suffered more frequently from upper limbs claudication ($p=0.026$). In the overall analysis, men had higher prevalence of arterial hypertension ($p=0.007$) and more frequent involvement of abdominal aorta ($p=0.026$), renal arteries (right, $p<0.001$; left, $p<0.001$) and iliac arteries (right, $p=0.009$; left, $p=0.002$). Women more frequently exhibited upper limb claudication ($p=0.042$) and involvement of left subclavian artery ($p=0.005$), carotid arteries (right, $p<0.001$; left, $p<0.001$) and supradiaphragmatic aorta (ascending, $p=0.050$; arch, $p<0.001$; descending, $p=0.003$). Inflammatory markers were more frequently raised in women ($p=0.005$).

Conclusion: In TAK patients, gender has a strong influence on pattern of vascular involvement and consequently on clinical presentation. Specifically, women have higher involvement of the supradiaphragmatic vessels, whereas in men the abdominal vessels are more frequently affected.

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Figure 1. Vessels affected at disease onset in 578 patients with TAK (108 male, 470 female) from 4 different cohorts, according to gender. Red: higher involvement in women, with statistical significance. Blue: higher involvement in men, with statistical significance. Yellow: no statistically significant difference between women and men.

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AB0622

THE EFFICACY OF ADDITIONAL TOCILIZUMAB IN PATIENTS WITH SEVERE POLYMYALGIA RHEUMATICA WHO WERE RESISTANT TO OR INTOLERANT OF CONVENTIONAL THERAPY

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Background: Polymyalgia rheumatica (PMR) is the most common inflammatory disease in the elderly. The 2015 EULAR/ACR recommendations indicate that the management of PMR should be started with glucocorticoids (GCs) and if needed, followed by addition of methotrexate (MTX). The anti-interleukin-6 (IL-6) receptor antibody, tocilizumab (TCZ), has been shown to be effective for PMR.

Objectives: To determine the efficacy and safety of TCZ in patients with refractory PMR who were resistant to or intolerant of GCs plus MTX and characterize the clinical profile of patients who need TCZ.

Methods: Patients were diagnosed with PMR by the 2012 EULAR/ACR provisional classification criteria and treated according to the 2015 ACR/EULAR recommendations for the management of PMR. TCZ was further added to the patients who were GC plus MTX (GC/MTX)-resistant or -intolerant. The efficacy of treatment was determined by measuring the disease activity with PMR activity score (PMR-AS). We statistically analyzed the differences in clinical indicators between GC-responders, GC/MTX-responders, and GC/MTX-non-responders who need TCZ therapy.

Results: Ninety-three patients (53 females and 40 males) were the average of 72.1 ± 9.4 years old, serum CRP 63 ± 42 mg/L, ESR 84 ± 34 mm/hr and blood platelet counts $331 \pm 86 \times 10^3/\mu\text{L}$, at the first visit, and had been followed up for 25.4 ± 19.6 months. All of them were treated first with prednisolone (PSL) (15.7 ± 4.3 mg/day). Relapses occurred in 43 patients (46.2%), at the PSL dose of 6.0 ± 5.6 mg/day, after 8.8 ± 6.7 month-GC treatment. GC was increased in 7 patients, and MTX (8.6 ± 2.9 mg/week) was added in 36 patients. Thirteen patients successfully discontinued GC, while 23 patients (24.7%) were resistant to or intolerant of GC/MTX. Ten of 23 patients agreed with TCZ therapy. Before TCZ addition, they were treated with PSL of 6.0 ± 2.2 mg/day plus MTX of 6.0 ± 3.8 mg/week, and serum CRP 9.7 ± 9 mg/L, blood platelet counts $271 \pm 32 \times 10^3/\mu\text{L}$ and PMR-AS 15.5 ± 13.5 . After 7.3 ± 4.2 month-TCZ treatment, PSL and MTX were reduced to 1.3 ± 1.6 mg/day and 2.2 ± 3.0 mg/week, and CRP, blood platelet counts and PMR-AS decreased to <0.2 mg/L, $191 \pm 28 \times 10^3/\mu\text{L}$ and 5.7 ± 8.3 , respectively. GC could be withdrawn in 7 patients, and 4 patients reached drug-free remission. There were significant differences in blood platelet counts and the initial PSL amount between GC/MTX responders and GC/MTX-resistant patients ($p<0.05$; Mann-Whitney U test).

Conclusion: TCZ may provide a therapeutic option for patients with refractory PMR who were resistant to or intolerant of GC/MTX. Our retrospective results suggest that patients with severe PMR, who show thrombocytosis and need high dose GC for initial therapy, may be considered for early induction of TCZ.

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AB0623

ANTI-NEUTROPHIL CYTOPLASMIC ANTIBODY-ASSOCIATED VASCULITIS AND RISK OF CEREBROVASCULAR ACCIDENT: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: An increased risk of cardiovascular disease, including cerebrovascular accident (CVA), among patients with chronic inflammatory immune-mediated disorders is well-recognized, especially among patients with rheumatoid arthritis and systemic lupus erythematosus [1]. Patients with anti-neutrophil cytoplasmic antibody-associated vasculitis (AAV) may