Active involvement	β	p	Active involvement	β	p
Mucocutaneous	0.243	<0.001	Ocular	0.378	<0.001
Gastrointestinal	0.216	0.001	Mucocutaneous	0.284	<0.001
Ocular	0.209	0.001	Gastrointestinal	0.192	<0.002
Vascular	0.108	0.086	Vascular	0.129	<0.027
Arthritis	0.088	0.185	Arthritis	0.121	0.048
Neurologic	0.003	0.962	Neurologic	0.047	0.420

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Figure. Correlation between PtGA and other outcomes measures

PtGA: patient's global assessment, PGA: physician's global assessment, BDCAF: Behçet's disease current activity form, PCS: physical component summary; MCS: mental component summary (MCS)

Abstract THU0299 – Figure 1

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THU0300 IMPACT OF VASCULAR ULTRASOUND ON EVALUATION OF GIANT CELL ARTERITIS AMONG 503 PATIENTS IN AN ACADEMIC MEDICAL CENTER

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Background: As vascular ultrasound (VUS) is increasingly used in evaluation of giant cell arteritis (GCA), its impact on clinical care is of great interest.

Objectives: To describe utilization of VUS in GCA evaluation at a large academic medical center and investigate impact of VUS on clinical impression.

Methods: We performed a retrospective cohort study of patients who underwent VUS at a single center in Boston, 2013-2017, to evaluate suspected or known GCA. Trained cardiovascular ultrasound technicians used a standardized protocol to image the temporal, carotid, subclavian, and axillary arteries for presence of hypoechoic circumferential wall thickening (halo sign), hyperechoic wall thickening, stenosis, and occlusion. VUS images were interpreted by trained cardiovascular medicine physicians as consistent with acute arteritis ("acute"), no evidence of arteritis ("none"), or hyperechoic wall thickening without halo sign ("hyperechoic"). Demographic, laboratory, medication, pathology and clinical data including the treating physician's clinical suspicion for GCA pre- and post-VUS were obtained by electronic medical record review. Fisher's exact test and Wilcoxon rank-sum tests compared baseline characteristics among patients with VUS positive for acute arteritis ("acute") vs. negative for acute arteritis ("none" or "hyperechoic"). We compared the treating physician's pre- and post-VUS clinical suspicion for GCA among patients with no history of GCA or aortitis.

Results: We identified 503 patients with median age 70.4 years; 69.0% were female and 87.5% White. VUS interpretation was acute in 48 patients (9.5%), none in 427 (84.9%), and hyperechoic in 28 (5.6%). Baseline characteristics are presented in Table 1. Weight loss, cranial symptoms, higher ESR, and steroid use were more common in patients with VUS positive for acute arteritis. Change in the treating physician's clinical suspicion for GCA is shown in Figure 1. VUS positive for acute arteritis increased suspicion for GCA in 26/35 (74%) cases, and VUS negative for acute arteritis lowered suspicion for GCA in 303/396 (77%). Of 110 patients with a temporal artery biopsy after VUS, 16 (14.6%) biopsies showed active arteritis; 11 of these were in patients with VUS negative for acute arteritis.

Conclusion: VUS result changed the clinical suspicion for GCA in approximately 75% of patients in this large cohort.

Abstract THU300 – Table 1. Characteristics at the time of VUS

Age, years	70.4 (62.7, 77.5)	73.2 (65.8, 79.7)	69.9 (62.6, 77.3)	NS
History of GCA or aortitis	14.3	27.1	13.0	0.02
History of PMR	31.2	22.9	32.1	NS
New headache	51.3	60.4	50.3	NS
Weight loss	13.3	22.9	12.3	0.05**
Fatigue	36.2	45.8	35.2	NS
Jaw claudication	10.9	33.3	8.6	<0.01
Scalp tenderness	17.1	37.5	15.0	<0.01
TA tenderness/decreased TA pulse	14.5	29.2	13.0	<0.01
Transient vision loss	7.8	10.4	7.5	NS
Permanent vision loss	3.0	6.3	2.6	NS
CRP*, mg/L	15.7 (3.1, 76.0)	36.3 (8.1, 81.9)	13.7 (2.9, 75.3)	NS
ESR*, mm/h	40 (18, 83)	67 (30, 95)	40 (17, 81)	<0.01
Steroids at time of VUS	57.5	75.0	55.6	0.01 0.02
>0 to <15mg/day	34.3	30.6	34.8	NS
≥15 to <40mg/day	23.5	8.3	25.7	
≥40mg/day	42.2	61.1	39.5	
Steroids ≥3 weeks	56.8	41.7	59.3	

Presented as% or median (interquartile range).

CRP: C-reactive protein; ESR: erythrocyte sedimentation rate; GCA: giant cell arteritis; PMR: polymyalgia rheumatica; TA: temporal artery; VUS: vascular ultrasound. NS: not significant.

*Among 418 patients with CRP and 370 with ESR checked within 3 weeks before VUS

**p=0.046

Figure 1. Treating physician's clinical suspicion for GCA before and after VUS among 431 patients without a history of GCA/aortitis

		VUS positive for acute arteritis (n=35)				
		Post-test impression				
		Definite GCA	Very likely GCA	Possible GCA	Unlikely GCA	Not GCA
Pre-test impression	Definite GCA	3	-	-	-	-
	Very likely GCA	13	3	-	-	-
	Possible GCA	8	3	3	-	-
	Unlikely GCA	1	1	-	-	-
	Not GCA	-	-	-	-	-

		VUS negative for acute arteritis (n=396)				
		Post-test impression				
		Definite GCA	Very likely GCA	Possible GCA	Unlikely GCA	Not GCA
Pre-test impression	Definite GCA	1	-	-	1	-
	Very likely GCA	4	9	7	9	5
	Possible GCA	3	2	35	41	141
	Unlikely GCA	-	-	2	20	99
	Not GCA	-	1	-	2	14

Increased suspicion	No change	Decreased suspicion
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Abstract THU0300 – Figure 1

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THU0301

SPLENIC INVOLVEMENT IS NOT RARE IN ANCA-ASSOCIATED VASCULITIS HOWEVER SPLENIC INFARCT MIGHT ONLY BE ASSOCIATED WITH GRANULOMATOSIS WITH POLYANGIITIS

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Background: Anti-neutrophil cytoplasmic antibody (ANCA) associated vasculitis (AAV) is a systemic necrotizing vasculitis of small and medium-sized arteries. Although, upper and lower respiratory tracts and kidneys are predominantly affected; other organs/systems can also be involved in the course of the disease and in some cases, it might be difficult to differentiate subgroups based on the clinical presentation. Splenic involvement has been rarely reported, mainly in patients with granulomatosis with polyangiitis (GPA), in fact, it was thought to be underestimated, as it is often asymptomatic.

Objectives: In this study, we aimed to investigate systematically the frequency of splenic infarct and related factors in our AAV patients. We also evaluated the role of splenic involvement in the differentiation of AAV subgroups.

Methods: Patients with a diagnosis of AAV in whom abdomen/thorax computed tomography (CT) was performed were included in the study. An experienced radiologist examined CT images for the presence of splenic involvement. The clinical and demographic data were retrospectively collected.

Results: In total 70 (30 [43%] female and mean age 56.1 ± 15.7 years) AAV patients (38 [54%] had granulomatosis with polyangiitis (GPA); 20 [29%] microscopic polyangiitis; 11 [16%] renal-limited disease and 1 [1%] eosinophilic granulomatosis with polyangiitis) were included in the analysis. Splenic pathologies including splenomegaly, hypodense lesion/s, lobulation, and infarction were seen in 21 (30%) patients with AAV. Splenic infarct was observed in seven (10%) patients and all had GPA with renal involvement and PR3ANCA positive. Three of them had total splenic infarct or auto-splenectomy. None of these patients had a history of endocarditis, shock or malignancy before CT. Splenic infarction was found to be negatively correlated with age at diagnosis ($p=0.017$; $\rho=-0.285$), and positively associated with ENT (ear-nose-throat) ($p=0.002$; $\rho=0.370$) and eye involvements ($p=0.013$; $\rho=0.324$).

Conclusion: Our results show that splenic pathologies might not be rare in AAV however, infarction can help to separate GPA from other AAVs. In young GPA patients, in particular, those with ENT and eye involvement, physicians should remember splenic infarction. Since almost half of our cases had severe infarction or autopsplenectomy, clinicians might consider immunization in GPA patients for vaccine-preventable infections.

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Abstract THU0301 – Figure 1. Computed abdominal tomography scan of one the patients with splenic infarction; transverse (a) and coronal images (b) show an irregular contoured shrunken spleen (arrows).

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THU0302

OUTCOMES OF PREGNANCY IN BEHCET'S DISEASE

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Background: Behcet's disease (BD) is multisystemic disease of unknown cause. The relationship between BD and pregnancy is reported in limited number of studies.

Objectives: To evaluate outcomes of pregnancies in BD patients (pts).

Methods: We retrospectively collected data of 22 women with BD diagnosis (according to ISGBD 1990 and ICBG 2014) and their 68 pregnancies. Pts' mean age was 30 [26;35] yrs, disease duration 7 [2;10] yrs. Ten (45,5%) pts had severe BD according to Ch.Zouboulis classification (due to generalized uveitis, retinal vasculitis and parenchymatous CNS lesions), while other 10 (45,5%) pts had mild disease with mainly dermal-mucous manifestations, and remaining two (9%) pts had moderate disease. These patients did not receive cytotoxic therapy.

Results: Sixty-eight pregnancies in 22 pts resulted in 45 live birth (4 cesarean section in 2 pts). Four patients had 11 medical abortions on request before 12 weeks of gestation, one patient - due to medical reasons (rubella on the 7th week of gestation). Seven (32%) out of 22 pts had adverse pregnancy outcomes. Five (23%) pts had 8 intrauterine deaths: one patient - 3 intrauterine deaths (4-10 weeks), two pts - 2 (10-12 weeks) and one - 1 intrauterine deaths (10 weeks). Two (9%) pts had 3 miscarriages 5-10 weeks. Antiphospholipid syndrome was never detected in pts from this cohort.

BD Severity and pathology of pregnancy

BD Severity	N=22 (%)	Intrauterine deaths/Miscarriage
Mild	10 (45,5)	3/2
Moderate	2 (9)	5/0
Severe	10 (45,5)	0/1

Out of 45 babies children born by BD patients only two had relapsing aphthous stomatitis and one - congenital glaucoma ("Neurobehcet" inherited from mother).

Conclusion: BD pts demonstrated high rates of adverse pregnancy outcomes. Unfavorable outcomes of pregnancy were documented in pts regardless (with all grades of) BD severity.