Conclusion: The annual hospitalization rates in connection with PMR diagnosis at South-west Denmark during a 5 year period were estimated to be 19.2%. The implementation of a FT ultrasound clinic decreased significantly the hospitalization rates among patients with PMR.

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FR10268

CLINICAL FEATURES OF TAKAYASU'S ARTERITIS FROM AN INCEPTION COHORT: EARLY DISEASE IS CHARACTERIZED BY 'SYSTEMIC INFLAMMATION'

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Background: There is only retrospective and very limited data for the long term prognosis of Takayasu's Arteritis (TAK), a rare large-vessel vasculitis.

Objectives: In this study, we aimed to present the preliminary results of a Takayasu Inception Cohort settled for long term, prospective follow-up of only newly-diagnosed patients with TAK.

Methods: Patients fulfilling the American College of Rheumatology 1990 criteria for TAK and diagnosed in the last 12 months were included to the study. Patients' data were recorded in an electronic database of an international "Takayasu's Arteritis Registry" requiring baseline and at least annual visits. Data is compared with an historical Turkish cohort previously published (Bıçakçılı, et al, 2009).

Results: The study included 170 patients (age: 38.5±13.1 years, F/M: 143/27) with TAK from 15 tertiary Rheumatology centers in Turkey. The mean symptom duration of patients was 5.2 years at diagnosis. According to the angiographic classification, 68.2% of the study group had type I and only 18.3% had type V disease. When we compared our results to our retrospective cohort (previously published by Turkish Takayasu Arteritis Study Group), constitutional symptoms (115/165= 69.6% vs 66%) and limb claudication (87/131= 66.4% vs 48%) were observed to be more frequent, whereas pulselessness (45/130=34.6%vs 88%) was less in the inception cohort.(Table 1) Carotidynia was present only in the inception cohort. Similarly, mucocutaneous symptoms also seem to be a feature of newly-diagnosed disease (30/162=18.5% vs 8.8%).

Regarding comorbidities at diagnosis, the rate of dyslipidemia was 17.6 (30/165)%, diabetes mellitus 15.1(25/165)%, smoking 20 (34/164)% and obesity (BMI>30) 14 (22/157)% among TAK patients. All patients were given oral corticosteroid (CS) therapy (0.5-1 mg/kg) at diagnosis, 17 patients (17/170=10%) also having CS pulses. In addition to CSs, 86 patients (50.6%) were given methotrexate, 31patients (18.2%) azathioprine, 6 (3.5%) cyclophosphamide, 12 patients (7.1%)leflunamide, 2(1.2%) patients mycophenolate mofetil and 5(2.9%) patients biologics at disease-onset(2 tocilizumab, 2 infliximab, 1 adalimumab). Biologic agents were chosen for 7 patients (7/32) at last visit(1 adalimumab, 4 tosiluzumab, 2 infliximab).

Seventy-three patients (42.9%) had follow-up > 3 months. Remission was observed 78% of patients. At least one relaps was observed 40% of these patients. Mortality rate was 4.1% (3/73 patients) during a mean 25.7 months follow-up.

Conclusion: Our results suggest that, in an inception cohort, signs and symptoms of 'systemic inflammation' is more prominent in newly-diagnosed TAK patients, whereas vascular extent and damage accumulates during the disease course. The long term follow-up of our inception cohort shows that 40% of patients relapse within 2 years after diagnosis in spite of IS treatments.

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Table 1. Clinical characteristics of Inception and Retrospective Cohorts from Turkey

	Inception Cohort (n=170)	Retrospective Cohort (Bıçakçılı, et al) (n=248)
Constitutional symptoms	115/165(69.6%)	163/248/ (66%)
Limb claudication	87/131(66.4%)	119/248 (48%)
Carotidynia	31/130 (18.2%)	-
Pulseless	45/130(34.6%)	218/248 (88%)
Musculoskeletal manifestations	90/163 (52.9%)	104/248 (42%)
Mucocutaneous manifestations	30/162 (17.6%)	22/248 (8.8%)
Respiratory manifestations	47/163 (28.8%)	22/184 (12%)
Neurologic manifestations	69/163 (40.6%)	156/248 (63%)
Cardiac involvement	64/146 (43.8%)	141/248 (57%)
Ophthalmologic involvement	27/166 (16.2%)	57/248 (36%)

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FR10269

COMPARATIVE STUDY OF INFLIXIMAB VERSUS ADALIMUMAB IN REFRACTORY UVEITIS DUE TO BEHÇET'S DISEASE. NATIONAL MULTICENTER STUDY OF 177 CASES

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Background: Uveitis is one of the major causes of disability of Behçet's disease (BD). According to the "Expert panel recommendations", anti-TNF therapy with infliximab (IFX) or adalimumab (ADA) may be considered as first- or second-line therapy for patients with BD-ophthalmic manifestations.

Objectives: To compare IFX versus ADA as first biologic drug in refractory uveitis due to BD for 1-year period.

Methods: Multicenter study of BD-associated uveitis refractory to conventional non-biologic treatment. Dosing schedule: IFX 3-5 mg/kg iv at 0, 2 and 6 weeks and then every 4-8 week, and ADA 40 mg/sc/every other week without loading dose. Main comparative outcome measures: safety and efficacy, assessing the intraocular inflammation, macular thickness, visual acuity, degree of immunosuppression load, drug retention, and glucocorticoid-sparing effect.

Results: 177 patients (316 affected eyes) were included. IFX was used in 103 and ADA in 74. No significant differences at baseline were observed regarding main demographic features, previous therapy and ocular severity. After 1 year of therapy, we observed an improvement in all ocular parameters in IFX vs ADA groups: AC inflammation (78.18% vs 92.31%), vitritis (78.95% vs 93.33%), retinal vasculitis (97% vs 95%), macular thickness (264.89±59.74 vs 250.62±36.85), and BCVA (0.67±0.34 vs 0.81±0.26). Drug withdrawal was observed in 57 (55.33%) of IFX group and in 21 (28.37%) of ADA group.

Conclusion: After 1 year of therapy in refractory BD-associated uveitis, ADA showed a statistically better outcome than IFX in improvement of BCVA, vitritis and drug retention.

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TABLE 1. Main baseline features and follow-up of a series of 177 patients with refractory uveitis due to Behçet's disease undergoing infliximab (IFX) or adalimumab (ADA) therapy.

	IFX group (N=102)	ADA group (N=75)	P
Number of patients/affected eyes, (n)	103/185	74/131	
Age, mean (SD) years	40.4 (10.1)	38.7 (11.3)	0.29
Sex, men/women, n/n	55/48	39/35	0.92
HLA-B*51 positive, (%)	89.4	88.9	0.74
Duration of uveitis before anti-TNF- α therapy, median (IQR) months	38 (12-72)	24 (12-60)	0.69
Ocular features at the time of anti-TNF- α onset			
AC cells, median (IQR)	1 (0-2)	1 (0-2)	0.25
Vitritis, median (IQR)	1 (0-2)	1 (0-2)	0.12
BCVA, mean (SD)	0.50 (0.30)	0.58 (0.34)	0.08
Macular thickness, mean (SD)	331 (11 (131-97)	348.37 (136.14)	0.49
Presence of retinal vasculitis, n (%)	114 (89)	78 (95)	0.51
Presence of choroiditis, n (%)	41 (23)	10 (7)	<0.01
Pattern of uveitis, n (%)			
Bilateral	82 (79.61)	57 (77.03)	0.68
Unilateral	21 (20.39)	17 (22.97)	0.68
Anterior	11 (10.68)	14 (18.92)	0.19
Posterior	28 (27.18)	14 (18.92)	0.19
Panuveitis	64 (62.14)	45 (60.81)	0.19
Intermediate	9 (9)	1 (1.35)	0.19
Treatment before anti-TNF- α onset, %			
Oral corticosteroids	95	88	0.08
Intravitreal pulses of MP	31	21	0.38
CSA	75	78	0.65
MTX	57	42	0.049
Other treatments	44	42	0.77
Prednisone dose at anti-TNF- α onset, mean (SD), mg/d	54.35 (15.84)	53.37 (17.52)	0.37
Combined treatment, %			
CSA	76.5	70.3	
MTX	21.8	19.2	
CSA	41.1	55.7	
MTX	35.3	21.1	
CFM	1.3	0.0	
MMF	1.3	3.8	
FK-506	1.3	0.0	0.35
Follow-up on anti-TNF- α therapy, mean (SD), months	31.52 (23.51)	26.48 (18.57)	0.13
Remission, n (%)	78 (76.47)	61 (82.43)	0.34
Relapses, mean (SD)	1.3 (2.62)	1.66 (8.62)	0.61
Drug withdrawal, n (%)	57 (55.33)	21 (28.37)	<0.01
...remission, n (%)	20 (19.41)	6 (8.45)	0.58
...inefficacy, n (%)	18 (17.47)	11 (14.86)	0.09
...severe side-effects/toxicity, n (%)	8 (7.78)	4 (5.88)	0.58
...others, n (%)	11 (10.68)	0 (0)	0.03
Serious side-effects, n (per 100 patients/year)	4 (1.48)	4 (2.48)	0.40

Abbreviations: ADA, adalimumab; AZA, azathioprine; CFM, cyclophosphamide; CSA, cyclosporine A; FK-506, tacrolimus; IFX, infliximab; IQR, interquartile range; MMF, mycophenolate mofetil; MTX, methotrexate; MP, methylprednisolone; SD, standard deviation; TNF- α , tumor necrosis factor alpha.

FR10270

APREMILAST IN NON-ULCER MANIFESTATIONS IN BEHÇET'S DISEASE. MULTICENTER STUDY OF 32 CASES IN CLINICAL PRACTICE

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Background: Behçet's disease (BD) is a variable vessel vasculitis with a wide and heterogeneous set of signs and symptoms. The inhibitor of phosphodiesterase-4 Apremilast (APR) has demonstrated efficacy in the treatment of oral and/or genital ulcers.

Objectives: To assess the efficacy and safety of APR in BD patients with manifestations different from mucocutaneous ulcers.

Methods: National multicenter retrospective study on 32 BD patients treated with APR at maintained standard dose of 30 mg twice daily.

Results: From a cohort of 49 patients with oral and/or genital ulcers related to BD and refractory to conventional and/or biological treatment, we selected the cases with another clinical manifestation/s (n=32, 23 women/9 men), mean age of 46.35±15.05 years. Non-apthous manifestations present at apremilast onset were: arthralgia/arthritis (15), folliculitis/pseudofolliculitis (12), asthenia (7), erythema nodosum (3), furunculosis (2), paradoxical psoriasis by TNFi (2), ileitis (2), deep venous thrombosis (2), erythematous and scaly skin lesions (1), fever (1), eating disorder (1), fibromyalgia (1), unilateral anterior uveitis (1) and neurobehçet (1). APR was used in monotherapy (n=3) or combined (n=29) with oral corticosteroids (20), colchicine (17), methotrexate (5), azathioprine (3), dapsone (1), tocilizumab (1), hydroxychloroquine (1) and/or mesalazine (1). The outcome of the different clinical symptoms is shown in TABLE. The patient with neurobehçet kept stable (paresthesias) during the 6 months of follow-up. The 2 cases of deep venous thrombosis and the case of anterior uveitis resolved with anticoagulants and adjuvant topical treatment, respectively. Furunculosis, folliculitis/pseudofolliculitis and ileitis were the manifestations that improved completely and rapidly. The cases of arthritis experienced improvement, while those with arthromyalgias presented a torpid evolution.

Conclusion: Our data show an improvement of the cutaneous follicular and intestinal clinic with APR and a stability of the neurological clinic, while the musculoskeletal manifestations were mostly refractory.

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TABLE. Outcome of non-apthous clinic with apremilast.

	1-2 Weeks	4 Weeks	3 Months	6 Months	12 Months	18 Months	24 Months
Non-apthous manifestations at APR onset (n)							
Neurobehçet (NCS vasculitis) (1)	NC	NC	NC	NC			
Unilateral anterior uveitis (1)	CR	CR					
Deep venous thrombosis (2)	CR (2)	CR (2)	CR (2)	CR (2)	CR (1)	CR (1)	CR (1)
Arthromyalgias (11)	CR (1)	CR (1)	PR (4)	PR (5)	PR (5)	NC (1)	NC (1)
	CR (10)	PR (2)	NC (1)	NC (1)			
Arthritis (4)	NC (3)	PR (2)	CR (1)	CR (1)	CR (1)		
	ND (1)	ND (1)	ND (1)	ND (1)			
Folliculitis/pseudofolliculitis (12)	CR (6)	CR (8)	CR (9)	CR (9)	CR (2)	CR (1)	
	PR (2)	PR (3)	PR (3)	NC (1)			
Furunculosis (2)	NC (5)	NC (1)	NC (1)				
	CR (2)	CR (2)	CR (1)				
Erythema nodosum (3)	PR (1)	PR (1)	CR (1)	NC (1)			
	ND (2)	NC (1)					
Psoriasis/erythematous-scaly skin lesions (3)	NC (2)	NC (2)	PR (3)	PR (2)	PR (2)	PR (1)	PR (1)
	ND (1)	ND (1)					
Ileitis (2)	CR (1)	CR (2)	CR (2)	CR (2)	CR (1)		
	PR (1)						
Asthenia (7)	CR (1)	CR (1)	CR (1)	NC (4)	NC (2)	NC (1)	NC (1)
	NC (6)	NC (6)	NC (6)				
Fever (1)	ND	ND					
Eating disorder (1)	ND	ND	ND				
Fibromyalgia (1)	NC	NC	NC				

Abbreviations: CR= complete response; (n)= number of cases; ND= non-data available; NC= no changes observed; PR = partial response.