Results: There was no statistically significant correlation between HLA B51 and systemic manifestations or disease activity or Doppler findings nor capillary parameters and morphology. There was statistically significant relation between HLA B51 and ankle brachial index.

There was statistically significant difference between patients and controls in EDV, RI of the carotid artery, and arterial, venous limb of the capillary, also the capillary lobe and length with lower values in the patients. There was statistically significant difference between patients and controls in carotid intima media thickness with higher values in patients, inspite of the absence of significant difference in lipid.

Conclusion: HLA B51 didn't link to different clinical presentation in BD; it is related to peripheral arterial affection only. BD patients had poor arterial compliance and increased arterial stiffness, there is preclinical atherosclerosis in BD not to related to the level of lipid profile.

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FRI0282 STATINS REDUCE RELAPSE RATE IN TAKAYASU ARTERITIS

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Background: Takayasu arteritis (TAK) is a chronic inflammatory disease, mainly affecting aorta and its major branches. Despite treatment with glucocorticoid and adjunctive immunosuppressive agent, relapse is common. Considering the high relapse rate, it is important to identify additional medications that may help sustain remission. Statins, as having anti-inflammatory and immunomodulatory effects, may be one such possibility. **Objectives:** To investigate the effect of statins on relapse of Takayasu arteritis (TAK), which frequently occurs after achievement of remission.

Methods: We conducted a retrospective study on TAK patients with active disease, diagnosed between 2012 and 2017. Relapse was defined as recurrence of active disease after achieving remission. Demographic and clinical parameters of patients who experienced relapse were compared to those who did not. To identify factors associated with relapse, multivariate Cox regression analysis with stepwise backward elimination was performed. Inverse probability of treatment weighting (IPTW)-adjusted analysis was used to evaluate the influence of statins on relapse.

Table. Multivariate Cox proportional hazard regression analysis estimating risk of relapse

	Adjusted hazard ratio	95% confidence interval	P value
Age	0.974	0.942–1.008	0.130
Hypertension	0.776	0.309–1.951	0.590
Carotidynia	2.348	1.002–5.505	0.050
LDL-cholesterol	1.007	0.986–1.028	0.510
Statin use	0.260	0.120–0.563	0.001

Abbreviation: LDL; low density lipoprotein

Results: Of the total 74 TAK patients, 40 (54.1%) patients received statins, whereas 34 (45.9%) patients did not. Relapse was observed in 36 (48.6%) patients of the total 74 TAK patients. Compared with patients who did not experience relapse, patients who experienced relapse were younger (44.5±13.5 years vs 34.1±12.6 years, p=0.001), had lower prevalence of hypertension (63.2% vs 38.9%, p=0.037), more commonly had carotidynia (7.9% vs 27.8%, p=0.025), had higher LDL-cholesterol (84.8±18.8 mg/dl vs 100.5±26.1 mg/dl, p=0.010), and were less commonly taking statins (71.1% vs 36.1%, p=0.003). These variables were included in multivariate Cox regression analysis. The use of statins was significantly associated with lower risk of relapse (adjusted hazard ratio 0.260, 95% confidence interval 0.120–0.563, p=0.001). Furthermore, IPTW-adjusted

analysis confirmed that statin use was associated with a lower risk of relapse (IPTW-adjusted hazard ratio 0.153, 95% confidence interval 0.038–0.616, p=0.008).

Conclusion: In TAK, statins can be beneficial in reducing relapse rate after achieving remission.

Covariates: age (continuous), hypertension (yes/no), carotidynia (yes/no), LDL-cholesterol (continuous), and statin use (yes/no)

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FRI0283 PRESENTATION AND MANAGEMENT OF GIANT CELL ARTERITIS IN A REAL-WORLD SETTING (ARTEMIS STUDY)

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Background: We have little real-world data in France on the natural history and management of patients with GCA.

Objectives: The objective of this observational study, named ARTEMIS, was to describe the characteristics and management of patients with GCA in real-life settings in France.

Methods: This was a cross-sectional, non-interventional, multicentre, single-visit survey, conducted among hospital-based physicians specialized in internal medicine or rheumatology. Investigators enrolled consecutive patients ≥ 50 years old seen for GCA and currently under treatment. Information on medical practices, such as patient characteristics and diagnostic journey, diagnostic methods and specific GCA treatments, were collected on an eCRF. GCA activity was assessed on a 100-mm VAS completed by the patients (PtGA) and physicians (PGA). GCA was considered active for VAS scores ≥ 10 mm. Newly diagnosed GCA was defined as diagnosis (Dg)-to-visit interval < 6 weeks. Onset of symptoms-to-Dg interval was classified as "short" (< 1 month), "intermediate" (1–3 months) and "long" (> 3 months). Descriptive statistics were used for quantitative and qualitative variables.

Results: Over the 3-month inclusion period (August–November 2018), 306 patients were recruited (females: 67.3%, age at Dg ≥ 70 years: 72.5%); 260 (85.0%) and 46 (15.0%) were followed by internists or rheumatologists, respectively. Overall, 39 (12.7%) had newly diagnosed GCA, 267 (87.3%) had a GCA duration ≥ 6 weeks (mean follow-up 24.0±27.0 months). Original referral of patients to specialized centres was from GPs (55.9%), ophthalmologists (10.1%), neurologists (6.9%), emergency physicians (5.6%), internists (4.2%) and rheumatologists (4.9%). Mean time to Dg was 3.3±6.9 months, with an "intermediate" Dg interval for 57.5% of patients. The most common prior medical histories were hypertension (45.8%), psychiatric disorders (10.1%), dyslipidemia (11.8%), diabetes (9.5%) and osteoporosis (5.9%); during follow-up psychiatric disorders, diabetes and osteoporosis were more often reported: 12.1%, 14.7% and 8.5% of patients respectively. Initial GCA presentations included cranial symptoms (89.5% of patients), constitutional symptoms (73.9%), polymyalgia rheumatica (48.4%), and other extra-cranial manifestations (34.0%). Initial mean ESR and CRP level were 73.0±30.7 mm/hr and 87.3±68.3 mg/l. Temporal artery biopsy, high-resolution temporal artery Doppler ultrasonography, ¹⁸FDG-PET and aortic angio-CT were performed for 84.7%, 31.2%, 26.4% and 29.7% of patients, respectively, and contributed to GCA Dg for 67.1%, 52.7%, 70.3% and 36.8%. At study visit, PtGA was 28.1±26.4 and PGA was 13.1±21.4. Ongoing medications included glucocorticoids (GC) for 273 (89.2%) patients (mean dose: 14.9±16.7 mg/d), methotrexate for 35 (11.4%) and tocilizumab for 44 (14.4%). In total, 122 (39.9%) patients had ≥ 1 relapse (mean number of relapses: 1.7±1.0) after a mean time to a first relapse of 13.3±12.8 months. Total cumulative oral GC dose was 5179±4987 mg. GCA-related complications occurred in 48 (15.7%) pts with eye disorders in 15 (5.2%).

Conclusion: This observational, cross-sectional study of a large number of patients provides insight into current medical practices for GCA in France. Despite extensive use of large-vessel imaging, the proportion of patients diagnosed with non-cranial GCA is small (10%). The substantial proportion of patients with relapsing disease results in high cumulative doses of glucocorticoids. The number of patients with tocilizumab treatment was slightly greater than that with methotrexate treatment.

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FRI0284

RESULTS OF A SYSTEMATIC LITERATURE REVIEW INFORMING THE 2018 UPDATE OF THE EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF LARGE VESSEL VASCULITIS: EVIDENCE TO GUIDE THE MANAGEMENT OF GIANT CELL ARTERITIS

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Background: The latest EULAR recommendations for the management of large vessel vasculitis (LVV) were published in 2009 (1). Since then, imaging has become a reliable diagnostic tool and new therapeutic options are available for giant cell arteritis (GCA), supporting the need to update the recommendations.

Objectives: To analyse the current evidence for the management (diagnosis/monitoring and treatment) of LVV to inform the 2018 update of the EULAR recommendations.

Methods: A systematic literature review (SLR) dealing with diagnosis/monitoring and treatment strategies for LVV, respectively, was performed. Medline, Embase and Cochrane databases were searched from inception until 31st December 2017. Evidence on imaging was excluded in light of recently published EULAR recommendations (2). We reviewed data relevant to GCA. Level of Evidence (LoE), was assessed in accordance with the 2009 Oxford Centre for Evidence-based Medicine.

Results: We identified 283 papers from the SLR. The implementation of a fast-track approach to diagnosis significantly lowered the risk of permanent visual loss compared to historical cohorts (Level of evidence – LoE 2b). The SLR confirmed the efficacy of prompt initiation of glucocorticoids (GC). There was no high-quality evidence on the most appropriate starting dose, route of administration, tapering and duration of GC (LoE 4). Patients with GCA are at increased risk of dose-dependent GC-related adverse events (LoE 3b). The addition of methotrexate (MTX) (LoE 1a) or tocilizumab (TCZ) reduced relapse rates and GC requirements (LoE 1b). There was no consistent evidence that anti-platelet agents given at the time of GCA diagnosis prevented future ischaemic events (LoE 2a). There was little evidence to guide monitoring of patients with GCA.

Conclusion: Results from a SLR confirmed the importance of a prompt diagnosis and rapid initiation of GC therapy. Patients with GCA are at an increased risk for GC-related comorbidities. MTX and TCZ can reduce GC exposure and relapse rates. There are yet no high-quality data to guide monitoring and duration of treatment in GCA.

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FRI0286

CUTANEOUS POLYARTERITIS NODOSA: A SUBSET OF SYSTEMIC PAN OR A DISEASE APART?

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Background: Cutaneous Polyarteritis Nodosa (cutaneous PAN) is a rare form of necrotizing vasculitis involving predominantly medium and small arteries. It is limited to the skin. The clinical course is mostly chronic, however it has a more favourable prognosis than systemic PAN. Cutaneous PAN may be preceded by infection, drugs intake or may reflect underlying inflammatory or autoimmune disease. The diagnostic criteria are controversial and in some cases overlapping with those of systemic PAN. Cutaneous PAN is limited to the skin, but occasionally patients present extracutaneous symptoms, namely: myalgia, arthralgia or multineuritis

Objectives: To describe the clinical manifestations of cutaneous PAN, emphasizing the extracutaneous manifestations, as well as comorbid associations.

Methods: Retrospective study (1989-2018) of patients with cutaneous PAN seen in a tertiary center: referral area 800.000 inhabitants. All the cases were reviewed regarding epidemiological, clinical, electromyographic, histopathological and laboratory findings. Infections and comorbid diseases were also reviewed.

Results: Twenty-three cases were recruited: 8 male (34.78%) and 15 female (65.22%) patients. Mean age at onset: 47 years (range 18-76). Mean follow-up period :105 months (range 12-380). Cutaneous manifestations included: subcutaneous nodules (95.65%), ulcers (52.17%), livedo *reticularis* (60.87%), livedo *racemosa* (8.70%), *atrophie blanche* (39.13%) and purpura (4.34%). Cutaneous PAN most commonly occurred on the legs (100%), followed by the thighs (47.83%), the upper limbs (39.13%) and the trunk (17.39%). The most frequent extracutaneous symptom were asthenia (78.26%). Extracutaneous manifestations, limited to the same area of cutaneous lesions, were myalgia (60.87%) and paraesthesia (56.52%). An electromyography was performed in 14/23 patients and mononeuritis multiplex was observed in 7 patients. Only one patient progressed to systemic PAN, with development of renal disease 12 month after the diagnosis. The following infections were identified: hepatitis C (2), tuberculosis (1), *Streptococcus pyogenes* (1) and rickettsia (1). Comorbid diseases included: autoimmune hypothyroidism (2), cutaneous psoriasis (1), recidivant polychondritis (1), adult onset Still's disease (1), ulcerative colitis (1), pulmonary idiopathic fibrosis (1) and acute myeloid leukaemia (1). Glucocorticoids were used at medium-high doses (20-40 mg/day) in 20 patients as induction therapy, and NSAIDs at full doses in the remaining 3. Thirteen patients (56.52%) developed relapsing forms. Of this, 12 patients (52%) needed associated immunosuppressive treatment to prevent relapse. The most widely used immunosuppressant was methotrexate, followed by mycophenolate or azathioprine.

Conclusion: A long-term follow-up, with careful anamnesis and examination, including electromyography, is necessary to better characterize the cutaneous and extracutaneous manifestations of cutaneous PAN. The progression to systemic involvement is infrequent and cutaneous PAN has a more benign course from a clinical, and prognostic point of view.