Performance of components of Year 3 Luton GCA FTP compared to final diagnosis at ≥6 months*

<table>
<thead>
<tr>
<th>Diagnostic Tool</th>
<th>No. of positive patients</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
<th>PPV %</th>
<th>NPV %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatologist CP GCA (High)***</td>
<td>90</td>
<td>60</td>
<td>98.3</td>
<td>93.8</td>
<td>86.1</td>
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<td>Rheumatologist CP GCA (Moderate &amp; High)***</td>
<td>90</td>
<td>88</td>
<td>63.5</td>
<td>48.9</td>
<td>93</td>
</tr>
<tr>
<td>Any halo on TAUS</td>
<td>85</td>
<td>81.5</td>
<td>91.4</td>
<td>81.5</td>
<td>91.4</td>
</tr>
<tr>
<td>Bilateral positive TAUS</td>
<td>85</td>
<td>59.3</td>
<td>98.3</td>
<td>94.1</td>
<td>83.8</td>
</tr>
<tr>
<td>TAB</td>
<td>28</td>
<td>69.2</td>
<td>100</td>
<td>100</td>
<td>78.9</td>
</tr>
<tr>
<td>LVI (CT or CT PET)</td>
<td>12</td>
<td>80</td>
<td>100</td>
<td>100</td>
<td>67.5</td>
</tr>
</tbody>
</table>

Combined diagnostic tests in the whole FTP:
- Using patient record to Oct 2019: 2 patients passed through twice
- **Before imaging/TAB**

Conclusion: Unlike Yr 2, the higher secure diagnosis rate in Yr 3 could not be attributed to shorter time on prednisolone or better equipment. The increase was likely due to several factors including further improved sonographer skill and increased confidence to withdraw steroids in insecure cases with low/moderate CP-GCA. This approach did not increase sight loss. Further reduction in TAB rate financially justified a 3rd FTP slot/wk created in Yr 3.

Each component of the FTP was an inadequate diagnostic tool. Combina-
tions of diagnostic tools are needed to obtain the highest sensitivity and specificity for GCA diagnosis. FTPs limit tests to the minimum required for secure diagnosis. The “gold standard” diagnostic test for GCA is the whole FTP combined.

Disclosure of Interests: None declared

References:
1. Schäfer et al Rheum (Ox) 2017:56(9);1479-83

Performance of components of Year 3 Luton GCA FTP compared to final diagnosis at ≥6 months*

The value of clinical and laboratory features to predict extent of large vessel vasculitis on PET CT

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Background: Giant cell arteritis (GCA) is an idiopathic vasculitis affecting large and medium-sized vessels. The pattern of arterial involvement is heterogeneous with two overlapping categories recognised: classical cranial GCA and extra-cranial GCA (or large vessel vasculitis – LVV) that predominantly affects the aorta and its proximal branches. Although LVV is present in around 80% of patients with cranial GCA, and around one third will develop large vessel complications, there are no guidelines for which patients should be screened for it (1). We sought to investigate whether clinical and laboratory features were a useful guide to the severity of LVV on FDG PET-CT.

Objectives: To retrospectively analyse whether baseline patient characteristics are able to predict the extent of large vessel vasculitis on PET-CT.

Methods: Clinical data for 65 patients referred for a PET-CT scan by Rheumatologist at the Freeman Hospital, Newcastle between January 2015 and May 2018 were retrospectively analysed. The most recent full blood count and inflammatory markers prior to the scan were used. Scans were reviewed by a consultant radiologist and trainee. The arterial network was split into ten potentially involved territories (aortic arch, thoracic aorta, abdominal aorta, iliac vessels, axillary, brachiocephalic, subclavian, carotid, vertebral and femoral arteries). Both the value of highest standardised uptake value (SUV max) and the number of territories affected between those on steroid treatment at the time of the scan and steroid-naïve patients, albeit the number of positive scans in those on steroid treatment was low (n=5).

Conclusion: These results suggest that clinical and laboratory features are a poor guide to predicting the maximal severity and extent of disease on FDG PET-CT.

Disclosure of Interests: None declared

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Sensitivity % Specificity % PPV % NPV

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<tr>
<th>Test</th>
<th>No. of positive patients</th>
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Conclusion: Unlike Yr 2, the higher secure diagnosis rate in Yr 3 could not be attributed to shorter time on prednisolone or better equipment. The increase was likely due to several factors including further improved sonographer skill and increased confidence to withdraw steroids in insecure cases with low/moderate CP-GCA. This approach did not increase sight loss. Further reduction in TAB rate financially justified a 3rd FTP slot/wk created in Yr 3.

Each component of the FTP was an inadequate diagnostic tool. Combinations of diagnostic tools are needed to obtain the highest sensitivity and specificity for GCA diagnosis. FTPs limit tests to the minimum required for secure diagnosis. The “gold standard” diagnostic test for GCA is the whole FTP combined.

Disclosure of Interests: None declared

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1. Schäfer et al Rheum (Ox) 2017:56(9);1479-83
sequela and a total of 5 (5.3%) deaths occurred. Characteristics of patients with and without poor outcome are presented in Table 2. In multivariable logistic regression analysis, factors associated with poor outcome were initial mRS (OR 24.2 (95% CI 3.16 – 108.67)) and age >= 40 at NBS diagnosis (OR 4.59 (95% CI 1.02 – 20.69)), meanwhile, headache at presentation was associated with a lower risk for poor outcome. (OR 0.22 (95% CI 0.05 – 0.91)).

Conclusion: Neurologic involvement is a detrimental manifestation of BS and causes disability, even death. Patients who have an initial disabling presentation in advanced age are more likely to have poor prognosis. Treatment intensification in this subpopulation might be considered.

References: None

Disclosure of Interests: None declared

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SAT0275

MAINTAINED BENEFIT IN HEALTH-RELATED QUALITY OF LIFE OF PATIENTS WITH GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB PLUS PREDNISONE TAPERING: RESULTS FROM THE OPEN-LABEL, LONG-TERM EXTENSION OF A PHASE 3 RANDOMIZED CONTROLLED TRIAL

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Background: In part 1 of the 52-week, double-blind GIACTA trial, patients with giant cell arteritis (GCA) who received weekly tocilizumab (TCZ) plus prednisone tapering reported improvement in the 36-item Short-Form Health Survey (SF-36) Mental Component Summary (MCS) and Physical Component Summary scores and FACIT-Fatigue scores that were statistically significant and clinically meaningful compared with patients who received prednisone alone.

Results: A prospective follow-up of 326 patients included in the registry has been analysed. There are 182 women (56%) and their average age (SD) at the time of diagnosis was 33 (13) years. The majority of them were Caucasian (91%). The median follow-up time from BD diagnosis was 180 months, and the prospective follow-up period from the inclusion in the registry was 80 months. The cumulative clinical manifestations until the initial registration were oral ulcers in 100% of patients, genital ulcers in 221 (68%), arthritis in 147 (45%), erythema nodosum in 96 (29%), fever in 82 (25%), thrombosis in 74 (23%), anterior uveitis in 76 (23%), retinal vasculitis in 46 (14%), posterior uveitis in 35 (11%), aseptic meningitis in 32 (10%), and other neurological manifestations in 15 (5%) patients. One hundred and fifty-six (48%) patients received immunosuppressants and 47 (14%) biological therapy.

During follow-up (period from the inclusion in the REGEB to the last visit) 68 (23%) patients presented at least a severe outbreak. The median time from the BD diagnosis to the first flare was 170 months. The main clinical manifestations were oral-genital ulcers in 43 (63%) patients, uveitis in 31 (45%), arthritis in 13 (19%), neurological in 16 (24%), vascular in 10 (15%), and gastrointestinal in 3 (4%) patients. Immunosuppressants were used in 37 (54%) patients and biological therapy in 14 (21%). Biological therapy was mostly used due to refractory disease, the majority of cases because of ocular manifestations. There were no differences in terms of age, sex, and previous clinical manifestations between patients who suffered from those who did not. Flares were more frequent in patients who had received previous immunosuppressive or biological treatment (35% vs 13% and 48% vs 19%, respectively) (p<0.001 in both cases), probably reflecting a more severe disease.

Conclusion: The long-term follow-up of BD patients from REGEB cohort showed that 10 years after diagnosis, a fifth of them may continue to present severe flares requiring systemic treatment. The use of biological therapy increased over time and their main indication was refractory disease.

Disclosure of Interests: None declared

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SAT0274

DESCRIPTIVE ANALYSIS OF FLARES DURING THE LONG-TERM FOLLOW-UP OF PATIENTS WITH BEHÇET’S DISEASE INCLUDED IN REGEB COHORT


Background: The long-term follow-up of BD patients from REGEB cohort showed that 10 years after diagnosis, a fifth of them may continue to present severe flares requiring systemic treatment. The use of biological therapy increased over time and their main indication was refractory disease.

Methods: The Spanish Registry of BD or REGEB (REGistro de la Enfermedad de Behçet as Spanish nomenclature) Project Group was created by the Spanish Internal Medicine Society in 2009 with the aim of compiling a large cohort of Spanish patients with this rare disorder. By July 2012, REGEB has collected 635 BD patients with a multicentre, longitudinal and consecutive design. Diagnostic of BD was performed on the basis of the International Study Group criteria for BD. Since inclusion in the registry, patients have been followed prospectively and new flares have been recorded, defined as those clinical manifestations which have required initiation or modification of immunosuppressive treatment, or prednisone dose at or higher than 10mg/d of prednisone during more than 1 month.

Results: A prospective follow-up of 326 patients included in the registry has been analysed. There are 182 women (56%) and their average age (SD) at the time of diagnosis was 33 (13) years. The majority of them were Caucasian (91%). The median follow-up time from BD diagnosis was 180 months, and the prospective follow-up period from the inclusion in the registry was 80 months. The cumulative clinical manifestations until the initial registration were oral ulcers in 100% of patients, genital ulcers in 221 (68%), arthritis in 147 (45%), erythema nodosum in 96 (29%), fever in 82 (25%), thrombosis in 74 (23%), anterior uveitis in 76 (23%), retinal vasculitis in 46 (14%), posterior uveitis in 35 (11%), aseptic meningitis in 32 (10%), and other neurological manifestations in 15 (5%) patients. One hundred and fifty-six (48%) patients received immunosuppressants and 47 (14%) biological therapy.

During follow-up (period from the inclusion in the REGEB to the last visit) 68 (23%) patients presented at least a severe outbreak. The median time from the BD diagnosis to the first flare was 170 months. The main clinical manifestations were oral-genital ulcers in 43 (63%) patients, uveitis in 31 (45%), arthritis in 13 (19%), neurological in 16 (24%), vascular in 10 (15%), and gastrointestinal in 3 (4%) patients. Immunosuppressants were used in 37 (54%) patients and biological therapy in 14 (21%). Biological therapy was mostly used due to refractory disease, the majority of cases because of ocular manifestations. There were no differences in terms of age, sex, and previous clinical manifestations between patients who suffered from those who did not. Flares were more frequent in patients who had received previous immunosuppressive or biological treatment (35% vs 13% and 48% vs 19%, respectively) (p<0.001 in both cases), probably reflecting a more severe disease.

Conclusion: The long-term follow-up of BD patients from REGEB cohort showed that 10 years after diagnosis, a fifth of them may continue to present severe flares requiring systemic treatment. The use of biological therapy increased over time and their main indication was refractory disease.

Disclosure of Interests: None declared

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