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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.1717

AB0506

GIANT CELL ARTERITIS: IS ROUTINE CLINICAL PRACTICE COMPREHENSIVE ENOUGH?

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Background: Recommendations to collect the most relevant information on disease course, treatment and outcomes in giant cell arteritis (GCA) has been proposed by EULAR to facilitate clinical research and to improve clinical care.

Objectives: To assess the quality of data collection in routine clinical practice according to EULAR recommendations and to describe baseline and follow-up characteristics of a retrospective cohort of patients with GCA.

Table 1. GCA-related signs and symptoms, laboratory and therapeutic data.

Item	Performed Baseline	Baseline n=39	Performed Follow-up	Follow-up n=112
Ocular symptoms	35/39 (89.7%)	15/35 (42.9%)	91/112 (81.2%)	29/91 (31.9%)
Permanent ocular symptoms	34/39 (87%)	9/34 (26.5%)	92/112 (82%)	28/92 (30.4%)
Headache	39 (100%)	30/39 (77%)	90/112 (80.4%)	13/90 (14.4%)
Scalp tenderness	31/39 (79.5%)	9/31 (29.8%)	88/112 (78.6%)	4/88 (4.5%)
Jaw claudication	34/39 (87%)	19/34 (55.85)	91/112 (81.2%)	6/91 (6.6%)
Cranial artery abnormality	27/39 (69.2%)	17/27 (63%)	69/112 (61.6%)	3/69 (4.3%)
Constitutional symptoms	35/39 (89.7%)	19/35 (54.3%)	90/112 (80.4%)	11/90 (12.2%)
PMR	35/39 (89.7%)	18/35 (51.4%)	92/112 (82%)	9/92 (9.8%)
ESR mean (SD)	33/39 (84.6%)	58.7 (32.1)	83/112 (74%)	14.6 (18.8)
CRP mean (SD)	31/39 (79.5%)	8.4 (7.9)	70/112 (62.5%)	1.3 (3.3)
Haemoglobin mean (SD)	38/39 (97.4%)	12.0 (1.7)	90/112 (80.4%)	12.9 (1.5)
Peripheral pulses	9/39 (8%)	3/9 (33.3%)	5/112 (4.5%)	2/5 (40%)
Large vessel involvement	8/39 (20.5%)	5/8 (62.5%)	7/112 (6.25%)	3/7 (42.8%)
Glucocorticoids median (IQR)	39 (100%)	102.5 (50-250)	112 (100%)	10.0 (5-15)
Synthetic DMARD	39 (100%)	8/39 (20.5%)	111/112 (99%)	17/39 (43.6%)
Biological DMARD	39 (100%)	0/39 (0%)	111/112 (99%)	3/39 (7.7%)
Antiplatelet agents	39 (100%)	6/39 (15.4%)	110/112 (98%)	25/110 (22.7%)

PMR: polymyalgia rheumatica, ESR: erythrocyte sedimentation rate, CRP: C-reactive protein, SD: standard deviation, IQR: interquartile range, DMARD: disease modifying antirheumatic drugs

Methods: We reviewed medical records of patients diagnosed with GCA in a tertiary academic center between 2004-2018. We included patients with available data at diagnosis and one year of follow-up. Data extraction included: demographics, diagnosis, GCA-related signs and symptoms, laboratory, imaging modalities, comorbidities and treatment. Data in the chart was then compared with the core set of parameters proposed for GCA registries and databases by EULAR. Major relapse, according to the EULAR 2018 definition, was independently assessed by two rheumatologists.

Results: 58 patients were identified, 39 met predefined inclusion criteria with 151 visits during first-year follow-up. Headache (100%; 80.4%), ocular symptoms (89.7%; 81.2%), constitutional symptoms (89.7%; 80.4%), polymyalgia rheumatica (89.7%; 82%) and jaw claudication (87%; 81.2%) were the most frequently collected items at baseline and follow-up. Weight and height (2.6%; 2.6%), peripheral pulses (8%; 4.5%), smoking status (41%; 21%), and blood pressure (61.5%; 4.5%) were the less frequently collected. Most patients lacked differential pressure measurement. Myocardial infarction, malignancy, serious infections, arterial hypertension, diabetes and osteoporosis were collected in every patient (39, 100%). Only 2 major relapses were identified (5%). Two (2) patients died during the one-year follow-up period. Table 1 provides information on GCA-related signs and symptoms, laboratory and therapeutic data.

Conclusion: Although data collection in routine care is usually comprehensive enough according to EULAR proposed data set, key components in physical exam mostly those aiming to detect large vessel involvement, should be addressed more carefully.

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Disclosure of Interests: Julia Martínez-Barrio Consultant of: UCB Pharma, Belén Serrano Benavente: None declared, Tamara Del Río Blasco: None declared, Alfonso Ariza: None declared, Juan Ovalles: None declared, Juan Molina Collada: None declared, Teresa González: None declared, Carlos Gonzalez Consultant of: Gilead, Janssen, Novartis, Speakers bureau: Abbvie, Celgene, Gilead, Janssen, Novartis, Pfizer, Roche, Isabel Castrejon: None declared, Jose Maria Alvaro Gracia: None declared

DOI: 10.1136/annrheumdis-2020-eular.4852

AB0507

INVASIVE ASPERGILLOSIS IN ADULT RHEUMATOLOGICAL PATIENTS IN SAINT PETERSBURG, RUSSIA.

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Background: Invasive aspergillosis (IA) is a severe opportunistic infection that is not well understood in rheumatological patients.

Objectives: To study risk factors, etiology, clinical manifestations and results of treatment of IA in adult rheumatological patients.

Methods: Retrospective analysis of 830 patients (1998-2019) with "proven" and "probable" IA (EORTC / MSG, 2019), adults - 699 (84%). The main group included 18 (3%) adult rheumatological patients with IA, a control group included 610 (87%) adult hematological patients. Rheumatological patients were older, the average age was 59 years (21–75) vs 45 years (18–79), $p = 0.005$, and among them there were more women – 56% vs 42%, $p = 0.01$.

Results: In rheumatological patients with IA, underlying diseases were ANCA-associated vasculitis (28%), granulomatosis with polyangiitis (22%), periarthritis (11%), systemic lupus erythematosus (22%), rheumatic heart disease (11%) and ankylosing spondylitis (6%). In the control group, underlying diseases were acute leukemia (45%), lymphomas (34%), chronic leukemia (9%), multiple myeloma (7%), myelodysplastic syndrome (3%), and other hematological diseases (2%).

The main risk factors for IA development in rheumatological patients were: systemic steroids use (89% vs 69%), prolonged lymphocytopenia (76% vs 65%, median - 14 vs 12 days), treatment in ICU (44% vs 18%, $p = 0.01$), acute or chronic renal failure (39% vs 1%, $p = 0.0008$) and immunosuppressive therapy (28% vs 25%). Severe neutropenia was noted significantly less frequently (18% vs 83%, $p = 0.0001$). Additional risk factors were decompensated diabetes mellitus (17% vs 2%, $p = 0.004$), previous surgery (17% vs 1%, $p = 0.001$) and organ transplantation (6% vs 0%). In rheumatological patients, lung (83% vs 98%, $p = 0.0001$) and ≥ 2 organs (6% vs 8%) involvement were less common. Heart (11% vs 0%), sinuses (6% vs 5%) and central nervous system (6% vs 4%) involvement more often developed. In rheumatological patients, respiratory failure (61% vs 37%, $p = 0.03$), hemoptysis (28% vs 7%, $p = 0.0001$) and chest pain (17% vs 7%, $p = 0.04$) were noted more often, less often - fever $\geq 38^{\circ}\text{C}$ (67% vs 85%,