METHODS: A temporary recommendation for use for infliximab in refractory TA was approved by the French National Drug Authorities (April 2014). Infliximab was administered to patients in case of disease activity with a NIH score ≥2 despite conventional therapy. Data regarding patient’s clinical, laboratory, imaging and treatments were obtained at baseline, and at each following visit until last visit (October 2017). TA activity was evaluated according to NIH criteria and GC requirement throughout the study.

RESULTS: Twenty-three patients were enrolled, including 19 female. The median age at inclusion was 33 years (Interquartile range, IQR: 23-44 years). At baseline, 17 (74%) patients were treated with GCs, at a median dose of 10mg/day (IQR: 0-21) of prednisone-equivalent. After a median follow-up of 36.9 months (IQR: 10-58.7), improvement of ≥1 NIH criterion of TA activity was achieved for 14/22 (64%) patients. The median GC dose was 8mg/day (IQR: 7-10) at 6 months; 5mg/day (IQR: 0-8) at 12 months and 0mg/day (IQR: 0-5) at 36 months of follow-up. Overall, infliximab originator had a significant GC-sparing effect between baseline and last follow-up (p=0.009).

CONCLUSION: This multicenter open-label cohort study suggests that infliximab originator is an effective GC-sparing treatment for TA refractory to conventional therapy.

Disclosure of Interests: None declared

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AB0511

INTERNATIONAL CONSENSUS ON ANCA TESTING AND INTERPRETATION BEYOND SYSTEMIC VASCLITIS

S. Moseev1, J. W. Cohen Tervaert1,2, Y. Ariyura1, D. Bogdanos1, C. Elena1, J. Damoiseaux1, M. Ferrante1, L. F. Flores-Suárez1,2, M. Fritzler1, P. Invernizzi1,2, D. Jayne1, J. C. Jennette1,2, M. Little1,2, S. P. McAdoo1,2, P. Novikov1, C. P. Pusey4, A. Radice1,2, A. D. Salama1,2, J. Savige1,2, M. Segelmark1,3,9, Y. Shoenfeld1,2,9,10, R. A. Sicinio1,2, M. J. R. De Sousa1,2,2, U. Specks23, B. Terrier2, A. Tzioufas2, S. Vermeire1, M. H. Zhao1, X. Bossuyt1. 1Sechenov First Moscow State Medical University, Moscow, Russian Federation; 2University of Alberta, Edmonton, Canada; 3Maastricht University Medical Center, Maastricht, Netherlands; 4Kyorin University School of Medicine, Tokyo, Japan; 5University of Thessaly, Larissa, Greece; 6University of Tübingen, Kirchheim-Teck, Germany; 7University Hospitals Leuven, Leuven, Belgium; 8Instituto Nacional de Enfermedades Respiratorias, Mexico City, Mexico; 9University of Calgary, Calgary, Canada; 10Università degli Studi di Milano-Bicocca, Monza, Italy; 11University of Cambridge, Cambridge, United Kingdom; 12University of North Carolina, Chapel Hill, United States of America; 13Trinity Health Kidney Centre, Dublin, Ireland; 14Imperial College London, London, United Kingdom; 15San Carlo Borromeo Hospital, Milan, Italy; 16Royal Free Hospital, London, United Kingdom; 17University of Melbourne, Melbourne, Australia; 18Lund University, Lund, Sweden; 19Skane University Hospital, Lund, Sweden; 20Sheba Medical Center, Tel Hashomer, Israel; 21Tel Aviv University, Tel Aviv, Israel; 22Centro de Medicina Laboratorista; Germano de Sousa, Lisbon, Portugal; 23Mayo Clinic, Rochester, United States of America; 24Hôpital Cochin, Paris, France; 25National and Kapodistrian University of Athens, Athens, Greece; 26Peking First Hospital, Beijing, China

Background: ANCA can be detected in sera from patients with autoimmune, inflammatory, infectious or neoplastic diseases.

Objectives: To issue a Consensus Statement on ANCA testing and interpretation beyond systemic vasculitis.

Methods: This Statement was prepared by a group of experts, based on the results of a comprehensive search in PubMed.

Results: In certain settings beyond systemic vasculitis, ANCA may have diagnostic, prognostic or monitoring relevance. Testing for PR3- and MPO-ANCA by specific immunoassays should be performed in any patient with clinical features suggesting ANCA-associated vasculitides and in patients with anti-GBM disease and idiopathic interstitial pneumonia. Routine ANCA testing is not recommended in patients with connective tissue diseases (CTD), autoimmune liver diseases, inflammatory bowel diseases, infections, and/or malignancy unless there is evidence for small vessel vasculitis. ANCA testing by specific immunoassays may be useful in patients with rheumatoid arthritis, systemic sclerosis or primary Sjogren’s syndrome who have kidney disease with a nephritic sediment or in patients with systemic lupus erythematosus if a kidney biopsy shows prominent necrotizing and crescentic lesions or proliferative lupus nephritis. ANCA testing may be justified in patients with suspected autoimmune hepatitis type 1, who do not have conventional disease-related autoantibodies, or in patients with inflammatory bowel diseases in case of diagnostic uncertainty to discriminate ulcerative colitis from Crohn’s disease. In these cases, ANCA should be tested by indirect immunofluorescence since target antigens are not well characterized. ANCA against bacterial/cellular/permeability-increasing protein may be a biomarker for deteriorating lung function and a poor prognosis in patients with cystic fibrosis.

Conclusion: ANCA testing is clinically relevant not only in patients with manifestations suggesting systemic vasculitis, but also in patients with certain other disorders, particularly in patients with anti-GBM disease or idiopathic interstitial pneumonia.

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AB0512

ALLERGIC PROFILE AND ALLERGEN-SPECIFIC IMMUNOTHERAPY IN EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA): A SINGLE CENTER OBSERVATIONAL STUDY

L. Moro1,2, A. Cariddi1, S. Sartorelli1, E. Della Torre1,2, T. Germano2, G. A. Ramirez1,2, E. Bozzolo1, M. R. Yacoub1, L. Dagnino1,2, IRCCS San Raffaele Hospital, Unit of Immunology, Rheumatology, Allergy and Rare Diseases, Milano, Italy; 3Vita-Salute San Raffaele University, Milano, Italy

Background: Eosinophilic granulomatosis with polyangiitis (EGPA), previously known as Churg-Strauss syndrome, is a systemic disease characterized by late onset asthma associated with small- and/or medium-size vessel vasculitis, besides eosinophil-mediated cytotoxic organ damage. About 20-30% of patients with EGPA displays allergic manifestations related with inhalant sensitization, while prevalence of food and drug allergy is unknown in this context. Moreover, some authors in the past have highlighted a role in favor of a possible role of allergen-specific immunotherapy (ASIT) as a trigger of disease.

Objectives: Aim of the present study is to establish the prevalence of each category allergen sensitization and to determine whether atopy or specific immunotherapy could influence clinical expression of the disease.

Methods: Our study consisted in a retrospective demographic and clinical data collection regarding EGPA history (including age at diagnosis, organ and tissue involvement, autobody profile) and the presence of allergic comorbidities or previous drug hypersensitivity reactions. Patients without either proven allergic reactions or positive tests have been excluded.

Results: Fifty-three (53) patients with definitive diagnosis of EGPA have been included in the analysis among which 25 (47.2%) with chronic respiratory allergy or previous acute allergic reaction. Among allergic patients 15 (60%) resulted sensitized towards inhalants and among them 13 (86.7%) displayed multiple sensitization. Drug allergy affected 13 patients (52%), food 4 (16%). Among 15 patients with respiratory allergy, 13 were eligible for allergen-specific immunotherapy (ASIT). Seven (7) subjects underwent ASIT prior EGPA diagnosis with an average time-to-EGPA of 16.2 years. No statistically significant difference was found in terms of sex, age at diagnosis, positivity for or specificity of anti-neutrophil cytoplasm antibodies (ANCA), eosinophil count at onset, pattern of clinical manifestations comparing allergic vs. non-allergic, ASIT vs. non-ASIT, ASIT vs. allergic, ASIT vs. eligible.

Conclusion: Among patients with EGPA allergies are highly prevalent, particularly towards inhalants and drugs. In the great majority of patients multiple sensitization profile is found. Atopy doesn't seem to be associated with specific patterns of disease presentation. The absence of correlation between inhalant ASIT exposure and variation in mode and time of EGPA onset doesn't support the hypothesis of a its potential role in triggering the disease.
AB0513
GLOMERULONEPHRITIS IN LEVAMISOLE-ADULTERATED COCAINE VASCULOPATHY (LACIV): A 51-CASE SERIES

C. Muñoz1,2,3, D. Jaramillo Arroyave1,2,3,4, L. Hernandez2, L. A. González2,2, G. Vásquez2, M. Restrepo Escobar2,2, R. González2, A. Vanegas2,2.

1Hospital Universitario San Vicente Fundación, Medellín, Colombia; 2Hospital Universitario San Vicente Fundación, Medellín, Medellín, Colombia; 3Grup de Epidemiología y Bioestadística Universidad CES, Medellín, Colombia

Background: Up to 88% of cocaine is tainted with levamisole, an anthelmintic withdrawn from the market due to toxicity. Since 2010 LACIV patients, characterized by retiform purpura, ear necrosis, multisystemic compromise and positivity for multiple autoantibodies, have been reported. Renal involvement is the most serious and heterogeneous clinical manifestation.

Objectives: To describe the renal involvement of patients with LACIV.

Methods: We describe the renal manifestations of a 51 case series with LACIV admitted in four high complexity institutions in Colombia from December 2010 to December 2019.

Results: All patients were mestizos, with median age of 32.5 years (SD 7.8), the male:female ratio was 4.7:1, and the time from symptoms to diagnosis 12 months (IR 3). Nephritis was found in 60.8%, with creatinine elevation in 61%, median 1.6 mg/dl (IR 3), 87% had proteinuria, median 3184 mg/day (IR 5735), 43% in nephrotic-range; 93% had hematuria and 48% pyuria and cilinduria. Biopsy was performed in 21 patients (64%), with immune complex mediated extracapillary glomerulonephritis (35%), immune complex mediated membranoproliferative glomerulonephritis (20%) pauci-immune proliferative glomerulonephritis (20%), membranous glomerulonephritis (15%), focal and segmental glomerulosclerosis (5%) and C3 mediated extracapillary glomerulonephritis (5%). Six patients (18%) died due to the vasculitis. Patients with nephritis had more upper airway involvement, retiform purpura, leukopenia, lymphopenia, anemia, hypocomplementemia, anti-PR3 and anti-MPO antibodies, compared to patients without nephritis.

Conclusion: Due to the higher abuse of cocaine and its contamination with levamisole, LACIV is an increasingly reported disease. Although skin manifestations are the most characteristic and prevalent, renal involvement is frequent, clinically and histologically heterogeneous, and potentially serious. Cytopenias, hypocomplementemia and anti-neutrophil cytoplasmic antibodies could identify patients at risk of nephritis.

References:

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AB0515

F. Muratore1, L. Boiard1, E. Galli1, G. Pazzolla1, A. Cavazzza1, G. Restuccia1, C. Saltarini1, Rheumatology Unit, AUSL-IRCCS di Reggio Emilia, Reggio Emilia, Italy; 2Rheumatology Unit, University of Modena and Reggio Emilia, Modena, Italy; 3Pathology Unit, AUSL-IRCCS di Reggio Emilia, Reggio Emilia, Italy; 4Rheumatology Unit, AUSL-IRCCS di Reggio Emilia and University of Modena and Reggio Emilia, Reggio Emilia, Italy

Background: The classification criteria currently used to define giant cell arteritis (GCA) were developed in 1990 by the American College of Rheumatology