(ACR), and strongly focus on patients with cranial manifestations. Patients with large-vessel GCA (LV-GCA) have less frequently cranial symptoms and a positive temporal artery biopsy, and are less likely to be captured by the ACR criteria. GiACTA, a trial of tocilizumab in GCA, has recognized the concept of GCA as a clinical syndrome, and included patients with cranial and/or polymyalgic symptoms as long as GCA diagnosis was supported by either biopsy or appropriate LV imaging results. However, these inclusion criteria were elaborated by experts and were not validated in patients with GCA.

Objectives: To compare the performance of the 1990 ACR classification criteria and the GiACTA inclusion criteria for the classification of GCA in a single-center cohort of patients with GCA.

Methods: All consecutive patients with a diagnosis of GCA seen between January 2008 and December 2016 in our center were included (GCA cohort). Control cohort consisted of consecutive patients with a negative temporal artery biopsy (TAB) performed in the same time period and a final diagnosis different than GCA. For both study cohort, the final diagnosis was made at the end of the follow-up period by consensus by 2 rheumatologists, who retrospectively evaluated all the medical records from symptoms' onset to December 2019, last visit, or death. Subjects were classified by each of the different criteria. TABs showing inflammation limited to adventitial or periadventitial small vessels were considered negative for both ACR and GiACTA criteria.

Two-by-two classification tables were generated to estimate sensitivity and specificity, and receiver operating characteristic (ROC) curves with corresponding areas under the curve (AUC) were calculated.

Results: 213 patients were included in the study (75% female, mean age 71.7 years). 55 patients had TAB showing transmural inflammation (TMI); 30 patients had TAB showing inflammation limited to adventitial or periadventitial small vessels (PAI); 67 patients had evidence of LV-GCA at imaging (LV-GCA) and 61 patients had TAB without inflammatory changes (negTAB). 1990 ACR and GiACTA criteria were satisfied respectively by 55 (100%) and 51 (93%) TMI, 18 (60%) and 1 (3%) PAI, 23 (35%) and 31 (46%) LV-GCA and 27 (44%) and none (0%) negTAB patients.

After a median follow-up of 52.6 months, 174 of the 213 (84%) patients had a final diagnosis of GCA (55 TMI, 22 PAI; 67 LV-GCA and 30 negTAB) and the remaining 33 patients had a diagnosis different than GCA (2 PAI and 31 negTAB). Sensitivity and specificity of 1990 ACR classification criteria for GCA were 67% and 90%, AUC (95% CI) 0.790 (0.715 – 0.864). Sensitivity and specificity of GiACTA inclusion criteria were 48% and 100%, AUC (95% CI) 0.740 (0.669 – 0.811). By adding systemic symptoms in the symptoms domain of GiACTA inclusion criteria, sensitivity increased to 59% and sensitivity remained 100%, AUC (95% CI) 0.792 (0.730 – 0.854).

Conclusion: Both 1990 ACR classification criteria and GiACTA inclusion criteria showed a good specificity but a low sensitivity in classifying patients with a clinical diagnosis of GCA from this large monocentric cohort. There is an urgent need for new classification criteria for GCA.

Disclosure of Interests: Francesco Muratore: None declared, Luigi Boiardi: None declared, Elena Galli: None declared, Giulia Pazzola: None declared, Alberto Cavazza: None declared, Giovanna Restuccia: None declared, Carlo Salvarani Grant/research support from: consulting and investigator fees from Abbvie, Pfizer, MSD, Roche, Celgene, Novartis, Consultant of: consulting and investigator fees from Abbvie, Pfizer, MSD, Roche, Celgene, Novartis

DOI: 10.1136/annrheumdis-2020-eular.6537

AB0516

INITIAL TREATMENT OF POLYMYALGIA RHEUMATICA PATIENTS: COMPARISONS BETWEEN GENERAL PRACTITIONERS AND THE RHEUMATOLOGIST.

A. Orya¹, N. Svendsen¹, P. Lage-Hansen¹, N. J. Kock¹, A. Diamandopoulos², S. Chrysidis¹. ¹Hospital of Southwest Jutland, University of Southern Denmark, Esbjerg, Denmark; ²Martina Hansen Hospital, Baerum, Norway

Background: Polymyalgia rheumatica (PMR) is the most common inflammatory rheumatic disease at persons > 50 years of age. It is clinically characterized by pain and stiffness in the neck, proximal shoulder, and hip girdle. (1) Glucocorticoid (GC) is the cornerstone of PMR treatment; the use is associated with potentially severe side effects (3). According to EULAR-ACR recommendations for the management of PMR, treatment should be individualized using the minimum effective GC dose. (2)

An initial prednisolone dose of > 15mg is associated with significantly higher risk for GCs related side effects (1) and GC doses higher than 25mg/day are discouraged because of the high risk of adverse events; furthermore, there is no evidence that such doses are more effective than lower doses (2,3).

In most countries, the vast majority of PMR patients are diagnosed and managed primarily by their General Practitioner (GP) (4)

Objectives: To compare the initial GC dose for PMR patients diagnosed by their GP versus an outpatient rheumatological clinic in Denmark.

Methods: All patients with the diagnosis of PMR in South-West Jutland Hospital, Denmark at the period of 2013 to 2018 were identified from an electronic register.

Patients with an already known rheumatic disease before the diagnosis of PMR, GCA symptoms at the diagnosis time or hospitalized at the diagnostic time were excluded.

Clinical and paraclinical data were collected from the patient's electronic journal.

Results: In a period of 6 years, 342 patients with PMR were identified. Of 342 patients 83 were diagnosed by their GP. No significant differences were found regarding demographic, clinical and paraclinical baseline characteristics between the two groups. No differences were identified regarding the treatment response. However the initial prednisone dose in patients diagnosed by the GP's was significantly higher ($p < 0.0001$) compared to the rheumatological outpatient clinic (Table 1) with an initial dose of ≥ 25 mg at over 50% of newly diagnosed cases (45 patients).

Table 1.

	Diagnosed by GPs N 83	Diagnosed by the rheumatological outpatient clinic N 259	P values
Age (years) $\pm$ SD	70,2 $\pm$ 8,2	70,58 $\pm$ 7,5	n.s*
Gender-female(%)	62,6%	56,7%	n.s*
Duration of symptoms (weeks) $\pm$ SD	12,34 $\pm$ 10	12,9 $\pm$ 13,4	n.s*
Age over 50 %	98,8%	99,6%	n.s
Bilateral shoulder pain (%)	95,1%	96,5%	n.s
Abnormal CP and/or SR (%)	87,8%	94,2%	n.s*
CRP (mg/l) $\pm$ SD	36,8 $\pm$ 32,2	45,8 $\pm$ 36,8	n.s*
SR(mm/hour) $\pm$ SD	50,1 $\pm$ 26,5	55,1 $\pm$ 23,7	n.s*
Morning stiffness	87,9%	91%	n.s*
Hip pain or limited range of motion	66,2%	70,4%	n.s*
RF and aCCP negative %	87,9%	90,2%	n.s*
Absence of other joint involvement	79,5%	71%	n.s*
Initial prednisolone dose(mg) $\pm$ SD	25,65 $\pm$ 12,1	16,4 $\pm$ 4,5	<0,0001
Response to treatment	93,9%	94,1%	n.s

*non-significant

Conclusion: Our study shows that the initial GC dose is significantly higher for PMR patients diagnosed by GPs which may lead to a higher risk of GC related side effects.

References:

- [1] Camellino D, Dejaco C. Update on treatment of polymyalgia rheumatica Reumatismo. 2018 Mar 27;70(1):59-66. doi: 10.4081/reumatismo.2018.1062.
- [2] Dejaco C, Singh YP, Perel P, et al. 2015 recommendations for the management of polymyalgia rheumatica: A European League Against Rheumatism/American College of Rheumatology collaborative initiative. Ann Rheum Dis. 2015; 74: 1799-807
- [3] Dejaco C, Singh YP, Perel P, et al. Current evidence for therapeutic interventions and prognostic factors in polymyalgia rheumatica: a systematic literature review informing the 2015 European League Against Rheumatism/American College of Rheumatology recommendations for the management of po. Ann Rheum Dis. 2015; 74: 1808-17.
- [4] Helliwell T, Muller S, Hider SL, Zwierska I, Lawton S, Richardson J, Malen C. Challenges of diagnosing and managing polymyalgia rheumatica: a multi methods study in UK general practice. Br J Gen Pract. 2018 Nov;68(676):e783-e793. doi: 10.3399/bjgp18X699557.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.3260

AB0517

USE OF POSITRON EMISSION TOMOGRAPHY IN RHEUMATOLOGY PRACTICE

Ö. Özdemir Işık¹, S. İsgören², A. Yazıcı¹, A. Cefle¹. ¹Kocaeli University School of Medicine, Rheumatology, Kocaeli, Turkey; ²Kocaeli University School of Medicine, Nuclear Medicine, Kocaeli, Turkey

Background: Positron emission tomography (PET), which is widely used in oncology, has recently been used as a guide in the diagnosis of vasculitis and activity monitoring.