Methods: Multicenter study of 39 patients with uveitis due to IMID refractory to glucocorticoids and conventional immunosuppressants. Efficacy of CZP was evaluated with the following ocular parameters: best corrected visual acuity (BCVA), anterior chamber cells, macular thickness and presence of retinal vasculitis. Efficacy of CZP was compared between baseline, 1st week, 1st and 6th month, and 1st and 2nd year. Statistical analysis was performed with the STATISTICA software (Statsoft Inc. Tulsa, Oklahoma, USA).

Results: 39 patients/56 affected eyes (18 men/21 women) with a mean age of 40.5±11.9 years were studied. IMIDs included were: spondyloarthritis (n=17), psoriatic arthritis (6), Crohn (3), JIA (2), Behçet (2), reactive arthritis (2), rheumatoid arthritis (1), relapsing polychondritis (1), pars planitis (1), Birdshot (1) and idiopathic uveitis (3). Uveitis pattern was as follows: anterior (n=30), posterior (4), panuveitis (3) and intermediate (2).

Previous CZP, patients received: oral prednisone (n=18) methylprednisolone bolus (1), methotrexate (22), azathioprine (10), cyclosporine (4), leflunomide (2), mycophenolate mofetil (2) and cyclophosphamide (1). 77% of patients had received previous biological therapy, with a mean of 1.6±1.2 biological drugs per patient. Gestational desire was the reason for prescribing CZP in 8 patients. CZP was administered in monotherapy in 16 patients and in the remaining 23 patients combined with conventional immunosuppressants.

After a median follow-up of 24 [6-36] months, most of the ocular variables analysed showed a rapid and significantly sustained improvement (Table). CZP was discontinued in 11 patients for the following reasons: remission (n=1), insufficient response of ocular symptoms (n=1) and limited response of extraocular manifestations (n=9). No serious adverse effects were reported.

Conclusion: CZP seems to be effective and safe in patients with refractory uveitis due to IMID.

Table

	Baseline	1 st week	1 st Month	6 th Month	1 st year	2 nd year
BCVA (mean±SD)	0.77±0.29	0.77±0.30*	0.82±0.29*	0.85±0.26*	0.86±0.27*	0.88±0.23*
Tyndall (median [IQR])	0 [0-2]	0 [0-2]	0 [0-1]*	0 [0-0]*	0 [0-0]*	0 [0-0]*
OCCT (mean±SD)	355±61.5	-	284.1±40.4*	-	224.8±121.1*	-
Retinal Vasculitis (eyes affected, %)	2 (3.6)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

*p<0.05

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THU0312

AUTOLOGOUS NON-MYELOABLATIVE HEMATOPOIETIC STEM CELL TRANSPLANTATION FOR REFRACTORY TAKAYASU ARTERITIS: A RETROSPECTIVE MULTICENTRE CASE-SERIES FROM THE AUTOIMMUNE DISEASES WORKING PARTY (ADWP) OF THE EUROPEAN SOCIETY FOR BLOOD AND MARROW TRANSPLANTATION (EBMT)

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Background: Takayasu arteritis (TAK) is a chronic granulomatous large-vessel vasculitis, characterized by arterial thickening and fibrosis leading to stenosis and vascular occlusions. More than 10-20% of patients are refractory to conventional immunosuppressive therapy. Autologous hematopoietic stem cell transplantation (AHSCT) has emerged as a promising treatment option in severely affected and refractory patients with various autoimmune diseases and vasculitis, particularly ANCA-positive vasculitis and Behçet's disease.

Objectives: This study, approved by the ADWP, aims to evaluate the use and outcome of AHSCT in adult TAK patients.

Methods: This is a retrospective survey of patients reported to the EBMT registry between 1998 and 2019, who received AHSCT primarily for TAK. Clinical and laboratory data, including data on diagnosis, previous lines of therapy, transplant regimen, treatment-related mortality, as well as data regarding course of disease and treatment were recorded.

Results: Data from six adult patients treated with AHSCT between 2003 and 2019 for refractory Takayasu have been identified. Median (ranges) follow-up was 9.9 (1-14) years. Five patients were female (83%), median age was 25 (9-39) years at diagnosis and 28 (22-41) years at HSCT. All patients were pretreated with a median of 6 (4-8) lines of therapy, including systemic steroids (6 patients), methotrexate (5 patients), cyclophosphamide, mycophenolate mofetil or infliximab (4 patients), tocilizumab or etanercept (2 patients), and other biologic or conventional-synthetic DMARDs. Conditioning included cyclophosphamide and rabbit anti-thymocyte globulin in all patients. At six months post-transplantation, remission was obtained in all cases, which persisted at 12 months in 5 cases. Four patients reactivated TAK at a median time of 27 (7-52) months after AHSCT, and 3 resumed disease-modifying therapy. At last follow-up, all patients were alive, 2 patients were in remission (off-therapy), 2 patients improved compared to baseline, and 2 patients were in complete and partial remission, respectively, under immunosuppressive treatment.

Conclusion: This small retrospective series demonstrates that AHSCT has the potential to provide significant clinical responses in TAK patients who had been unresponsive to previous immunosuppressive therapy, with an acceptable safety profile.

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THU0313

DISEASE PATTERN AND TIME TO DIAGNOSIS IN A FAST-TRACK GIANT CELL ARTERITIS CLINIC USING ULTRASOUND AS PRIMARY DIAGNOSTIC TOOL

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Background: Giant Cell Arteritis (GCA) is a vasculitis predominantly affecting the large vessels from aorta and its proximal branches and extra-cranial arteries. Precise and fast diagnosis is important in order to initiate proper treatment and avoid ischaemic events, e.g. irreversible visual loss. Unnecessary and prolonged glucocorticoid treatment is also unwanted due to its significant side effects. Therefore, immediate diagnosis of GCA is recommended, and the primary diagnostic tool, according to EULAR recommendation, is vascular ultrasound (US)¹. In 2018, a GCA Fast-Track Clinic (FTC) was implemented in our department covering a population of approximately 900.000. Patients even with a low a-priori suspicion of GCA were accepted. It is the aim to have patients seen within one office day.

Objectives: In this retrospective study, to describe clinical data from patients seen in the FTC in a 1-year period from September 1st, 2018 and to investigate the time required for making a diagnosis, and to which extent US as the primary diagnostic tool was adequate for making the final diagnosis.

Methods: All patients, irrespective of clinical presentation, had US of bilateral temporal-, facial-, axillary and common carotid arteries done (exam time 30 min.). All US were done by ultrasonographers with experience and training in vascular US. Immediately after the initial US, patients were seen by a senior registrar in rheumatology at our out-patient clinic. The senior registrar was aware of the conclusion of the US. Decisions on further diagnostic procedures were solely up to this rheumatologist. From electronic patient report files, all patients' clinical- and US-findings as well as results from other diagnostic procedures (temporal artery biopsy (TAB) and positron emission tomography computed tomography (PET-CT)) were evaluated. Furthermore, final diagnosis and fulfilment of ACR1990 classification criteria for temporal arteritis at three months was noted, as was the number of days required for diagnosis.

Results: A total of 120 patients were seen in the FTC and had a vascular US done. Demographic and clinical data are seen in table 1. Of 120 patients, 42 (35%) had a clinical diagnosis of GCA at three months and 42% fulfilled ACR1990 criteria for temporal arteritis. Based on US alone, 36% of patients had GCA. A