with eGFR and TP clinically (β=0.955, 3.349; p=0.025, 0.008), and with CS pathologically (β=1231, p=0.028). Neither AS nor AS-WL was included in the prognostic factors. Kaplan-Meier method with log-rank tests showed a significant difference in cumulative rate of CKD and/or death between CS ≥3 and CS <3 groups (p=0.049).

Conclusion: AS and CS were related to different clinical parameters at the time of renal biopsy. CS was associated with renal and life prognoses, while neither AS nor AS-WL was. These results revealed that these scores have different clinical pathologic significance in LN.

References:

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Vasculitis


References:

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Objectives: To compare presenting and prognostic features of LV-GCA and C-GCA patients after an adequate vascular imaging evaluation at baseline.

Methods: Data from GCA patients followed-up at our institution were retrospectively collected. Only patients who underwent large-vascular imaging (PET, CTA, MRA) at disease onset or within one week after steroid introduction were included. Patients with evidence of LV involvement were classified as LV-GCA. Differences between LV-GCA and C-GCA patients regarding presenting features, treatment, and prognosis were evaluated. Non-parametric tests were used.

Results: In our cohort, we identified 161/280 patients who underwent LV-imaging study at baseline. Of these, 100 (62.1%) had signs of LV inflammation. Table 1 compares demographical factors, diagnostic delay, pre-existing comorbidities and complementary treatment between the 2 groups. Table 2 compares disease features at diagnosis. Mean follow-up was similar between LV- and C-GCA patients (31.8±3.1 v 27.8±2.9 months; p=0.738). Corrected cumulative prednisone dose (CCPD, grams/months) was equivalent (LV, 0.67±0.57; C, 0.87±1.37; p=0.871). A DMARD was added in 73% of LV- and in 55.7% of C-GCA patients, but, notably, it was introduced at baseline in 52% of LV- vs 23.5% of C-GCA patients (p=0.006). CCPD was equivalent even considering only patients who did not receive DMARDs (LV, 0.92±0.81; C, 0.94±1.18; p=0.522).

Rate of monophasic and infectious complications was similar, in terms of arterial hypertension (LV, 3%; C, 0%; p=0.286), diabetes (2% vs 0%, p=0.524), osteoporotic fractures (7% vs 5%, p=0.742), severe infections (3% vs 3.3%, p=1).

Ongoing complementary treatment between the 2 groups. Table 2 compares disease features at onset in LV and C-GCA patients.

Conclusion: LV-GCA patients are younger and suffer of a greater diagnostic delay. Although a greater systemic inflammation seems to be a feature of LV-GCA patients, the vascular prognosis is similar to C-GCA patients, who, conversely, have a greater incidence of ocular complications.

References:

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