Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.4284

Vasculitis – large vessel vasculitis

AB0352 ANTICARDIOLIPIN ANTIBODIES AND ACTIVITY OF GIANT CELL ARTERITIS

A. Hočevár^{1,2}, R. Jese¹, J. Kramarič¹, S. Cucnik¹, M. Tomsic^{1,2}, Z. Rotar^{1,2}.
¹University Medical Centre Ljubljana, Department of Rheumatology, Ljubljana, Slovenia; ²Medical Faculty, University of Ljubljana, Internal Medicine, Ljubljana, Slovenia

Background: Anticardiolipin antibodies (aCL) can be detected in newly diagnosed GCA as reactive antibodies to endothelial lesions. Their prognostic role, as a marker of disease activity, has not been extensively studied in GCA.

Objectives: Our aim was to determine whether aCL IgG might represent laboratory marker of active GCA.

Methods: We included patients with new clinical diagnosis of GCA supported by histology or imaging between September 2011 and July 2019, who completed at least a 48-week follow-up at our secondary/tertiary rheumatology center. Follow up visits with predetermined clinical and laboratory tests, including aCL IgG, were performed 12, 24, 48, and 96 weeks after diagnosis. GCA relapse was defined as worsening or new disease activity after initial remission. Other reasons for the disease-related symptoms, elevated inflammatory markers (C reactive protein or erythrocyte sedimentation rate) had to be excluded. aCL IgG were determined in the patients' sera samples at baseline and at follow up visits, using an in-house solid phase enzyme-linked immunosorbent assay¹. A value above the 99th percentile of the healthy control population was taken as significant.

Results: During the observation period we identified 288 newly diagnosed GCA patients. Two hundred and twelve GCA patients (66.5% females, median (IQR) age 73.9 (67.0–78.7) years) fulfilled the study inclusion criterion, among them 145 patients completed the 96-week follow up visit. At baseline, 129/212 (60.8%) GCA patients had positive aCL IgG. During in total 781 follow up visits, we recorded 77 (9.9%) episodes of active/relapsing GCA (clinical, laboratory or combined in 4 (5.2%), 48 (62.3%), 25 (32.5%) episodes, respectively). aCL IgG were present at 155/781 (19.8%) measurements (at 24/77 episodes of relapsing/active and 131/573 episodes of quiescent GCA). The correlation between active/relapsing GCA and aCL IgG positivity was only weakly positive (r coefficient=0.094; $p=0.015$).

Conclusion: The role of aCL IgG as a biomarker for GCA activity seems to be rather limited.

REFERENCES:

[1] Božič B, et al. *Int Arch Allergy Immunol.* 1997; 112:19-26. doi.org/10.1159/000237426

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2021-eular.322

AB0353 ADRENAL INSUFFICIENCY AFTER GLUCOCORTICOID TREATMENT OF GIANT CELL ARTERITIS

A. Hočevár^{1,2}, R. Jese¹, J. Kramarič¹, M. Tomsic^{1,2}, Z. Rotar^{1,2}. ¹University Medical Centre Ljubljana, Department of Rheumatology, Ljubljana, Slovenia; ²Medical Faculty, University of Ljubljana, Internal Medicine, Ljubljana, Slovenia

Background: Adrenal insufficiency is frequently neglected and underappreciated, potentially severe complication of systemic glucocorticoid therapy.

Objectives: We aimed to evaluate the prevalence of glucocorticoid induced adrenal insufficiency in giant cell arteritis (GCA).

Methods: We analysed adrenal function data in a cohort of GCA patients diagnosed between July 2014 and July 2019, in whom discontinuation of methylprednisolone therapy was planned. Adrenal function was tested by Corticotropin stimulation test (CST). To perform the CST, methylprednisolone was substituted with hydrocortisone (20mg qd in three divided doses) for one to four weeks before the test. Adrenal insufficiency was defined as cortisol level <450 nmol/l measured 30 minutes after the corticotropin injection; additionally, the result of the CST was defined as borderline when the cortisol level 30 minutes after corticotropin injection was between 450 nmol/l and 500 nmol/l.

Results: Adrenal function was tested in 74/215 GCA patients before definite methylprednisolone withdrawal (after a median 13.5 (12.9 – 22.4) months of glucocorticoid therapy). The mean (SD) methylprednisolone dose, prior to substitution with hydrocortisone and subsequent CST, was 3.1 (1.6) mg. Adrenal insufficiency was detected in 36/74 patients (48.6%); additionally, 10/74 patients (13.5%) had a borderline CST result. Seventeen patients with either adrenal insufficiency or borderline CST result, had a repeated CST after median (IQR) 11.6 (8.9; 12.6) months. Adrenal insufficiency persisted in 11/17 (64.7%) patients, and 1/17 patients had a borderline CST. A third CST was performed in 4/12 patients with abnormal second CST after median (IQR) 8.3 (6.9; 10.6) months. Adrenal function recovered in one patient, while the adrenal insufficiency persisted in the remaining 3 patients.

Conclusion: Adrenal insufficiency is a common and potentially long-lasting glucocorticoid induced adverse event in GCA patients.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.323

AB0354 FDG-PET-DETECTED LARGE VESSEL VASCULITIS DOES NOT PREDICT DISEASE OUTCOME IN PATIENTS WITH GIANT CELL ARTERITIS AND POLYMYALGIA RHEUMATICA

E. Hysa¹, D. Camellino², C. Bernini³, E. Gotelli⁴, S. Paulino¹, C. Schenone⁴, G. Ferrari⁴, A. Sulli¹, M. Cutolo¹, M. A. Cimmino⁴.
¹Laboratory of Experimental Rheumatology and Academic Division of Clinical Rheumatology, Department of Internal Medicine, University of Genoa, Genoa, Italy; ²Division of Rheumatology, Local Health Trust 3, Musculoskeletal System Department, Genoa, Italy; ³Operational Unit of Internal Medicine 2, Department of Internal Medicine, University of Genoa, Genoa, Italy; ⁴Laboratory of Experimental Rheumatology and Academic Division of Clinical Rheumatology, Department of Internal Medicine, University of Genoa, Genoa, Italy

Background: Giant cell arteritis (GCA) and polymyalgia rheumatica (PMR) are tightly associated inflammatory conditions of the elderly [1]. Both disorders can exhibit an increased articular and vascular uptake of 18-fluorodeoxyglucose (18-FDG) at positron emission tomography (PET)/computed tomography (CT) scan [2].

Objectives: This study evaluated if large-vessel vasculitis (LVV) detected by PET/CT in patients with PMR and/or cranial GCA had a negative prognostic value.

Methods: 108 patients (35 men and 73 women) with a median age of 74 years (range 50-92 years) were prospectively enrolled in our centre over 4 years. PMR was diagnosed by Bird et al. criteria and GCA by the ACR criteria. Six patients died shortly after the first visit (V_0) and six were lost at follow-up. Of the remaining 96 patients, 77 were classified as PMR, 6 as GCA and 13 were affected by both diseases.

At V_0 , patients underwent a clinical, laboratory and PET/CT evaluation, and were stratified according to the presence or not of LVV. Follow-up visits