were performed every 6 months for a median of 40 months. Disease outcomes were: prednisone (PDN) use and its cumulative dosage, need of methotrexate (MTX), number of relapses, patients' death, and PMR disease activity score (PMR-DAS). The independent variables were age, sex, disease duration, fever, C-reactive protein (CRP) concentration, platelet count (PLT), presence of cranial GCA, degree of joint and vascular uptake of FDG, and presence of LVV. The predictive role of LVV was tested by multiple regression.

Results: LVV was seen in 47 patients (49 %), 31 with PMR, 6 with GCA and 10 with both diseases. Patients with or without LVV did not significantly differ in terms of demographic and laboratory parameters except for a non-significant higher number of PLT in patients with LVV. Clinical and laboratory parameters at V_0 , stratified per disease and considered together, did not significantly change between PET+ and PET- patients (table 1). Lastly, none of the independent variables, including LVV, could predict disease outcomes.

Conclusion: The presence of a PET-detected LVV at diagnosis does not seem a negative prognostic factor in PMR and GCA. As a consequence, routine investigation by PET/CT of patients with PMR and GCA is not indicated to predict disease outcome.

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Table 1. Clinical, laboratory and imaging features between PET+ and PET- patients at V_0

Features at V_0	PET+ patients	PET- patients	p
Morning stiffness (min)	30 (0-480)	60 (0-360)	0.20
Haemoglobin (g/dL)	12.3±1.5	12.6±1.5	0.28
Platelets (x 10 ⁹ /mm ³)	349 (108-643)	297(159-571)	0.08
C-reactive protein (mg/dL)	35.5 (3.4-149)	36.2 (2-149)	0.54
Erythrocyte sedimentation rate (mm/h)	62.5 (10-120)	57.5 (10-120)	0.29
Total Vascular Score at PET	20 (4-41)	6 (0-12)	0
Total Joint Score at PET	18 (5-30)	18 (5-32)	0.77

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AB0355

THE VALUE OF PLATELET-TO-LYMPHOCYTE AND NEUTROPHIL-TO-LYMPHOCYTE RATIOS AS INFLAMMATORY MARKERS IN BIOPSY-PROVEN GIANT CELL ARTERITIS

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Background: Platelet-to-lymphocyte ratio (PLR) and neutrophil-to-lymphocyte ratio (NLR) have been shown to correlate with disease activity in various rheumatic diseases. High PLR and elevated platelet count are potentially useful in diagnosing some systemic vasculitides, eg. giant cell arteritis (GCA)¹ and has been suggested predictive for diagnosing GCA, even in the absence of characteristic temporal artery involvement².

Objectives: To evaluate the role of PLR and NLR as inflammatory markers in the diagnosis of GCA in patients referred to temporal artery biopsy (TAB).

Methods: During 10 months, all patients referred to TAB at the Department of Ophthalmology (Rigshospitalet, Copenhagen, Denmark) in suspected GCA were included. Immediately prior to TAB, ultrasound of bilateral temporal arteries was performed at the Center for Rheumatology and Spine Disease (Rigshospitalet, Copenhagen, Denmark) by rheumatologists experienced in vascular ultrasound. Ultrasound signs of GCA were a positive Halo sign or compression sign. Patients had C-reactive protein (CRP), erythrocyte sedimentation ratio (ESR), platelets, white blood cells with differential counts, hemoglobin and platelets measured. Final clinical diagnosis, based on rheumatological expert opinion, and fulfilment of ACR1990 classification criteria for temporal arteritis at six months was noted, with clinical diagnosis being the reference standard.

Results: 106 patients were included and had a TAB evaluated. Forty-five (42%) had a clinical diagnosis of GCA at 6 months of which 28 (62%) also were TAB positive. US was performed in 74 (70%), of these 20 (67%) of the GCA patients had a positive ultrasound for GCA (termed US GCA patients). There was no significant difference in mean age or gender distribution between GCA and non-GCA patients. ESR, CRP and platelets were significantly higher in GCA than non-GCA patients ($p < 0.001$). PLR was significantly higher in GCA than non-GCA patients ($p < 0.007$), while NLR was not ($p = 0.076$). For US GCA patients vs. US non-GCA patients, platelets were significantly higher in the US GCA group ($p = 0.025$). Both PLR and NLR were significantly higher in the US GCA group compared to the US non-GCA group ($p = 0.003$ and $p = 0.007$, respectively).

Conclusion: In this cohort of patients, suspected of GCA and referred to TAB, PLR but not NLR was significantly higher in GCA patients than in non-GCA patients. In patients with US findings of GCA, both PLR and NLR were significantly higher in GCA compared to non-GCA. An elevated PLR could be considered an additional feature in diagnosing GCA.

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	GCA (n=45)	Non-GCA (n=61)	P-value
Age (years)	73.6 (7.5)	72.6 (10.4)	0.575
Females, n (%)	34 (76)	38 (62)	0.148
Fulfilling ACR1990 criteria, n (%)	36 (80)	16 (26)	<0.001
TAB positive for GCA, n (%)	28 (62)	0 (0)	<0.001
Ultrasound positive for GCA*, n (%)	20 (67)	9 (20)	<0.001
Sedimentation rate (mm/hr)	58 (30)	33 (31)	<0.001
Haemoglobin (mmol/L)	7.68 (0.92)	7.96 (1.05)	0.154
CRP (mg/L), median (IQR)	38 (15-92)	8 (2-40)	<0.001
White blood cells (10 ⁹ /L)	9.54 (3.18)	8.99 (3.63)	0.407
Lymphocytes (10 ⁹ /L)	1.72 (0.78)	1.87 (0.93)	0.367
Monocytes (10 ⁹ /L)	0.71 (0.37)	0.77 (0.41)	0.441
Neutrophils (10 ⁹ /L)	6.85 (2.94)	6.01 (3.02)	0.157
Basophils (10 ⁹ /L)	0.05 (0.04)	0.05 (0.05)	0.464
Eosinophils (10 ⁹ /L)	0.15 (0.14)	0.18 (0.21)	0.410
Platelets (10 ⁹ /L)	400 (154)	289 (111)	<0.001
Neutrophil-to-lymphocyte ratio	4.91 (3.22)	3.87 (2.52)	0.076
Platelet-to-lymphocyte ratio	287 (189)	193 (147)	0.007

Values are mean and standard deviation unless noted. Comparison between groups by independent samples t-test (continuous variables), χ^2 -test (categorical variables) and Mann-Whitney for CRP (not normal distributed continuous variable). ACR=American College of Rheumatology; CRP=C-reactive protein; GCA=giant cell arteritis; IQR=interquartile range; n=number; SD=standard deviation; TAB=temporal artery biopsy*Ultrasound not done in 32 patients (15 with GCA and 17 without)

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AB0356

VENOUS INVOLVEMENT IN BEHÇET'S DISEASE

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Background: Behçet's disease (BD) is a vasculitic multisystem inflammatory disorder. It may also involve the skin, mucosa, eyes, blood vessels, joints, gastrointestinal system, and central nervous system.

Objectives: In this study, we aimed to present venous involvement data in patients followed up with a diagnosis of BD.

Methods: The clinical, demographic, laboratory and medication data of 394 patients who were followed up with a diagnosis of BD in our

rheumatology outpatient clinic between 2000 and 2020 were retrospectively evaluated.

Results: Venous involvement was detected in 17.6% (n:76) patients who were followed up with a diagnosis of BD. 75% of the patients were male, and their mean diagnosis age was 27.1 ± 9.9 , disease duration was 14.2 ± 6.3 years. While the thrombosis of lower extremity veins, cervical veins, and vena cava were observed in 85.5% of BD patients, superficial thrombophlebitis was found in 31.6%. Cerebral venous involvement (CVI) was evaluated in cranial involvement. Oral aphthous ulcer was found in 97.4 % of the patients, genital ulcer in 65.8%, pathergy positivity in 44.7%, papulopustular lesion in 34.2%, erythema nodosum in 40.8%. 27.6% of the patients were evaluated for hereditary thrombophilia and 5.3% (n:7) had hereditary thrombophilia. Deep venous thrombosis was found in 85.7% (6/7) of these patients, renal artery occlusion in 14.3%, pulmonary artery thrombosis in 14.3%, and cerebral venous thrombosis in 28.6%. Patients with and without venous involvement were compared in terms of clinical findings. A significant difference was observed in terms of retinal vasculitis, artery occlusion, arterial aneurysm, family history for BD and gender. In logistic regression analysis, a significant relationship was observed between venous involvement and gender, family history, retinal vasculitis, artery occlusion, arterial aneurysm (Table1).

Table 1. Comparison of data of patients with and without venous involvement

	Venous Involvement (+) n:76	Venous Involvement (-) n:318	P	OR* (%95CI)
Gender			0.000	2.78 (1.58-4.88)
Female	19(25)	153(48.1)		
Male	57(75)	165(51.9)		
Family History	4(5.3)	44(13.8)	0.049	0.035 (0.12-0.99)
Oral Aphthous Ulcer	74(97.4)	305(95.9)	0,745	
Genital Ulcer	50(65.8)	206(64.8)	0,894	
Papulopustular lesion	26(34.2)	103(32.4)	0,786	
Erythema Nodosum	31(40.8)	119(37.4)	0,601	
Pathergy	34(44.7)	151(47.5)	0,772	
Uveitis	20(26.3)	118(37.1)	0,083	
Retinal Vasculitis	5(6.6)	6(1.9)	0.036	3.66 (1.08-12.33)
Arthritis	13(17.1)	85(26.7)	0,104	
Artery Occlusion	6(7.9)	3(0.9)	0.002	8.97 (2.19-36.74)
Arterial Aneurysm	7(9.2)	8(2.5)	0.013	3.93 (1.37-11.20)
Gastrointestinal involvement	6(7.9)	11(3.5)	0,111	
Cardiac involvement	3(3.9)	3(0.9)	0,089	
Cranial involvement	7(9.2)	17(5.3)	0,282	

* Significant data in logistic regression analysis were presented

Conclusion: Superficial venous thrombosis and deep vein thrombosis are the most frequent vascular involvements in BD patients. Significant correlations exist between CVI and pulmonary artery involvement (PAI), intracardiac thrombosis and PAI. It should be recalled that lower extremity venous thrombosis is often present in these associations, and even precede them (1).

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AB0357 LANDSCAPE REVIEW OF PATIENT-REPORTED OUTCOME MEASURES IN GIANT CELL ARTERITIS

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Background: Giant cell arteritis (GCA) is a systemic large vessel vasculitis that results in symptoms (e.g., headaches, jaw claudication, fatigue, pain, etc.) that can have multiple negative impacts on an individual's health-related quality of life.

Objectives: To identify important symptoms and impacts experienced by individuals with GCA, develop a conceptual model, and evaluate available patient reported outcome (PRO) measures for appropriateness for inclusion in GCA clinical studies.

Methods: Published literature on disease experience from databases, conference abstracts, and Guidance/OMERACT documents were reviewed. A GCA conceptual model was developed based on the symptoms and impacts identified from this literature and supplemented with clinical input. A detailed review of selected PROs was then conducted to assess concept coverage and gaps to evaluate appropriateness for a GCA population.

Results: Of 245 identified citations, 24 abstracts and 18 articles were reviewed. Key symptoms affecting GCA patients (e.g., ischemic and constitutional symptoms) and impacts to the lives of GCA patients (e.g., reduced physical, social and emotional functioning) formed the basis for a GCA conceptual model (see Figure 1).

No GCA-specific PROs were identified. Therefore, the PROs that were used most frequently in GCA clinical studies were reviewed and evaluated. These included the SF-36, FACIT-Fatigue, Patient Global Assessment (PtGA), Multidimensional Fatigue Inventory (MFI), EQ-5D, Health Assessment Questionnaire (HAQ), Brief Illness Perception Questionnaire (BIPQ), and Visual Functioning Questionnaire-25 (VFQ-25). These PROs included some key impacts but did not assess most GCA-specific symptoms (e.g., headaches, fever, etc.). No measures were developed with input from GCA patients and there has been limited evaluation of the measurement properties of these PROs in GCA patients.

The FACIT-Fatigue, SF-36, and the PtGA, which were frequently administered in published GCA studies, measure key GCA concepts such as fatigue, functioning, impact on daily activities and disease status. The measurement properties (reliability, validity, sensitivity to change) have been documented in several other rheumatologic diseases (Table 1).

Conclusion: In the absence of a GCA-specific PRO, the SF-36, FACIT-Fatigue, and PtGA are recommended for use in GCA clinical studies for the assessment of key concepts identified in the literature. Qualitative and quantitative research should be conducted with GCA patients to assess the content validity and measurement properties of these PROs in a GCA population.