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.

Table 1. Summary of Recommended Measures

Description	SF-36	FACIT-Fatigue	PtGA
Type	Generic, health status measure	Fatigue and impact on function/daily activities	Measure of disease activity
Method of Administration	Self/Interviewer	Self/Interviewer	Self
# of Items	36	13	1
Recall period	Past 4 weeks/past week	Past 7 days	Varies
Scoring	8 domain scores; 2 component summary scores	Total score	Total score
Measurement properties	Measurement properties demonstrated in other rheumatologic diseases (SLE, RA, SpA, and chronic knee pain); construct validity demonstrated in a single study with GCA patients	Measurement properties demonstrated in rheumatologic populations including SLE, PsA, and RA	Select measurement properties have been demonstrated in GCA and other populations (RA, TAK, RP)
Concept coverage	GCA impacts (emotional, physical, and social functioning, and daily activities), bodily pain, fatigue	Fatigue	Overall assessment of disease activity
Administered in recent GCA studies	YES	YES	YES

SLE= systemic lupus erythematosus, SpA = spondyloarthritis, PsA=psoriatic arthritis, RA=rheumatoid arthritis, GCA= giant cell arteritis, TAK= Takayasu's arteritis, RP=relapsing polychondritis

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AB0358 ABATACEPT AS A bDMARD IN STEROID-REFRACTORY POLYMYALGIA RHEUMATICA

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Background: polymyalgia rheumatica (PMR) is a chronic inflammatory disorder affecting elderly people. Glucocorticoids (GC) are the mainstay of therapy for PMR. Despite this treatment, the disease may relapse or GC dosage cannot be tapered. Methotrexate (MTX) may be helpful in these cases. Blockade of IL-6 has an effective steroid-sparing effect in patients with giant cell arteritis (GCA) and may improve the clinical symptoms of patients with PMR. The pathophysiology of PMR still remains uncertain but there are evidences for a participation of Th1 and Th17 lymphocytes. Recently, blockade of the costimulatory pathway by abatacept (ABA) gave favorable results in GCA.
Objectives: to report our experience (efficacy and safety) of ABA in the treatment of patients with isolated PMR who required longstanding GC and who failed to respond to MTX and/or IL-6 receptor blocking agents.
Methods: a call for observations of all cases of patient with PMR who received at least one dose (SC or IV) of ABA was sent to the members of the French specialist network "Club Rhumatismes & Inflammation" (CRI: www.cri-net.com)(rheumatologist and internal medicine). Patients must satisfy the EULAR/ACR criteria for PMR and have isolated PMR without associated GCA.
Results: 4 cases were declared during a 12 months period: 2 men and 2 women; age (median [range]): 60.7 [50-68] years; disease duration 30 [7-48] months; duration of GC treatment before starting ABA: 60 [10-72] months.

They all required prednisolone with a daily dosage of 14.5 mg [10-20]. Before ABA administration, they all received MTX while 2 patients were treated by IL-6R inhibitor (tocilizumab 6 months and sarilumab 3 months, respectively) without improvement. ABA was given as a monthly infusion (10 mg/kg) in one case and subcutaneously (every week) in 3 cases. ABA treatment duration ranged from 3 to 18 months. Two patients responded to the treatment with a progressive decline of DAS-PMR and GC dosage tapering during a 12 month follow-up, while there was no improvement for the 2 others (Table 1). CRP levels also decreased for one responder. The safety was excellent for all. ABA was still maintained in one responder. Among the non-responders, one patient was switched to tocilizumab and the second still received high GC dosage.
Conclusion: ABA may be effective in certain PMR patients who were unable to taper GC, with a good safety profile. A randomized controlled trial is required in order to determine its place in the treatment of PMR and to select the appropriate patients who could potentially benefit from this biological agent.
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Table 1. changes in DAS-PMR and CRP levels in 4 patients with PMR while receiving abatacept (M: months; CRP in mg/L).

Cases	DAS- PMR M0	DAS- PMR M3	DAS-PMR M6	DAS- PMR M12	CRP M0	CRP M3	CRP M6	CRP M12
1	20	21	21	NA	5	8.6	8.4	NA
2	31.1	30.5	NA	NA	21	25	NA	NA
3	10.7	8.35	5	13	37.2	22.7	22	22
4	18	22	17.2	12	1.2	3.3	3.5	3

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AB0359 CRANIAL 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 (CNS).
Objectives: In this study, we aimed to present CNS 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: CNS involvement was detected in %5.6(24) patients who were followed up with a diagnosis of BD. 66.7% of the patients were male, and their mean diagnosis age was 25.1±8.2 years, mean CNS involvement age was 28.39±9.6 years. Neurological symptoms occurred in an average of 3.3 years after the diagnosis of BD. Parenchymal involvement was present in 54.2% of the patients with CNS involvement, 45.8 % had cerebral venous thrombosis. Oral aphthous ulcer was found in 91.7 % of the patients, genital ulcer in 70.8%, pathergy positivity in %45.8 papulopustular lesion in %37.5, erythema nodosum in %45.8. Patients with CNS involvement had headache, vision loss, diplopia, hemiparesis, epilepsy, proptosis, and ataxic gait and walking difficulty in 66.6%, 12.5%, 25%, 12.5%, 8.3%, 8.3% and 12.5%, respectively. Patients with and without CNS involvement were compared in terms of clinical findings and medications. A significant difference was observed in terms of cardiac involvement (Table 1). While one of the 2 patients with cardiac involvement had a thrombus in the right ventricle, the other had pericardial effusion. The patient with cardiac thrombus also had cerebral venous thrombus. Steroid, azathioprine, cyclophosphamide treatments have been used at a higher in patients with CNS involvement. In addition, the patients with parenchymal and cerebral venous involvement were compared in terms of clinical, demographics findings and medications. The presence of papulopustular lesions (9.1% vs 57.1%) and pathergy positivity (18.2% vs 71.4%) were higher in patients with parenchymal involvement (p:0.033, p: 0.020, respectively).