at 1, 3, 6 and 12 months, respectively. Prednisone dose was reduced from 30.0 [12.5-50.0] to 5.0 [0.0-5.6] mg/day at 12 months (Table 1). 10 (26.3%) of the 38 patients in whom an imaging follow-up test was performed showed no radiographic improvement after a median of 9.0 [6.0-14.0] months. 4 of them were in clinical remission. 23 (42.6%) patients were on TCZ_{MONO} and 31 (57.4%) on TCZ_{COMBO}: MTX (n=28), cyclosporine A (n=2), azathioprine (n=1). Patients on TCZ_{COMBO} were younger (38.0 [27.0-46.0] vs 45 [38.0-57.0] years; $p=0.048$), with a trend to longer TAK duration (21.0 [6.0-38.0] vs 6.0 [1.0-23.0] months; $p=0.08$) and higher C-reactive protein (2.4 [0.7-5.6] vs 1.3 [0.3-3.3] mg/dL; $p=0.16$). Despite these differences, similar outcomes were observed in both groups (log rank $p=0.862$) (Figure 1). Relevant adverse events were reported in 6 (11.1%) patients, but only 3 developed severe events that required TCZ withdrawal.

Table 1.

	Baseline n=54	Month 1 N=54	Month 3 N=49	Month 6 N=44	Month 12 N=36
Clinical remission, n (%)		12 (22.2)	19 (38.8)	23 (52.3)	27 (75.0)
Laboratory improvement					
CRP (mg/dL), median [IQR]	1.5 [0.5-3.5]	0.2 [0.1-0.7]*	0.2 [0.5-0.5]*	0.2 [0.1-0.5]*	0.1 [0.0-0.4]*
ESR (mm/1 st hour), median [IQR]	30.5 [8.7-52.7]	7.0 [3.0-14.0]*	4.5 [2.0-8.0]*	5.0 [2.0-6.0]*	4.0 [2.0-9.5]*
Hemoglobin (g/dL), mean $\pm$ SD	12.4 $\pm$ 1.5	13.0 $\pm$ 1.2*	13.0 $\pm$ 1.4*	13.2 $\pm$ 1.5*	12.9 $\pm$ 1.6*
Prednisone dose, median [IQR]	30.0 [12.5-50.0]	20.0 [10.0-30.0]*	10.0 [5.0-20.0]*	5.0 [5.0-10.5]*	5.0 [0.0-5.6]*

CRP: C-Reactive Protein; ESR: Erythrocyte Sedimentation Rate; IQR: interquartile range; n: number. * $p<0.01$ vs baseline (Wilcoxon test).

Conclusion: TCZ is effective and safe in white patients with refractory TAK. A discordance between clinical and imaging activity assessment may exist.

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FIGURE 1

Disclosure of Interests: Diana Prieto-Peña Grant/research support from: DP-P has received research support from UCB Pharma, Roche, Sanofi, Pfizer, AbbVie and Lilly, Pilar Bernabéu: None declared, Paloma Vela-Casasempere: None declared, J. Narváez: None declared, Carlos Fernández-López: None declared, Mercedes Freire González: None declared, Beatriz González-Alvarez: None declared, Roser Solans-Laqué: None declared, Jose Luis Callejas-Rubio: None declared, Norberto Ortego: None declared, Carlos Fernández-Díaz: None declared, Esteban Rubio Romero: None declared, SALVADOR GARCÍA MORILLO: None declared, Mauricio Minguez: None declared, Cristina Fernández-Carballido: None declared, Eugenio de Miguel: None declared, Sheila Melchor: None declared, Eva Salgado-Pérez: None declared, Beatriz Bravo: None declared, Susana Romero-Yuste: None

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AB0367

DIAGNOSTIC DELAY IN PATIENTS WITH GIANT CELL ARTERITIS

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Background: Giant cell arteritis (GCA) is the most common systemic vasculitis in the elderly which can lead to severe complications when treatment is delayed. Therefore, timely diagnosis and start of treatment is essential. Several forms of delay (consultation, referral and diagnostic delay) can contribute to the total delay towards GCA diagnosis. In the Dutch healthcare system, treatment is not started by a general practitioner (GP). When GCA is suspected, GPs refer to specialists. In our hospital, a fast track clinic (FTC) is used to expedite diagnosis. However, information on factors contributing to delay is scarce.

Objectives: The aim of this study was to describe the different components of delay towards diagnosis in GCA suspected patients in a general hospital, Ziekenhuisgroep Twente (the Netherlands).

Methods: For this descriptive study, a retrospective cohort consisting of patients with suspected GCA between January 1st 2017 and October 1st 2019 was used to analyse components of delay in diagnosis, as suggested by Prior et al. Consultation delay was defined as the time between start of symptoms and a patient's first consultation with a GP. Referral delay was defined as the time between a patient's first consultation with a GP and first visit to the FTC. Diagnostic delay was defined as the time between the first visit to the FTC and treatment initiation. Total delay was defined as the time from symptom onset until start of treatment. Delays were described using the median and interquartile ranges (IQR).

Results: In our cohort, 206 patients were included for analysis of whom 62 had GCA. Controls (n=144) were suspected of but did not have GCA. Comparing GCA patients with controls, 66.1% and 50.7% were female and the mean (SD) age was 74.2 (9.4) and 70.2 (11.0) years, respectively. In our cohort, the majority of patients (n=42, 67.7%) had cranial GCA (C-GCA). Furthermore, 8 (12.9%) had large vessel GCA (LV-GCA) and 12 (19.4%) had a combination of C-GCA and LV-GCA. For GCA patients, median consultation delay was 2.1 (IQR 0.8-5.8) weeks, referral delay 1.4 (IQR 0.4-4.6) weeks and diagnostic delay 0 (IQR 0-0.1) weeks (Figure 1). For delay regarding consultation and referral, results of controls were comparable to GCA patients. The median total delay was 4.4 weeks (IQR 1.57-10.14) for GCA patients.

Conclusion: With a median total delay of 4.4 weeks, delay in our cohort is almost half the delay described in a review by Prior et al. This difference might be due to FTC implementation and subsequent awareness in our hospital and by local GPs. Patients generally received treatment within one day after FTC visit. Nevertheless, contribution of consultation and referral delay is not resolved by introduction of the FTC, as shown in our data. Timely diagnosis is essential as severe complications can develop instantly, which emphasizes the need to tackle consultation and referral delay.

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Table 1. Baseline characteristics of GCA patients and controls in our retrospective cohort. *CDUS=Colour Doppler Ultrasound; **Temporal Artery Biopsy; *18-FDG-Positron Emission Tomography/Computed Tomography.**

	GCA patients (n=62)		Controls (n=144)	
	Range		Range	
Gender, % female (n)	66.1 (41)		50.7 (73)	
Age (years), mean (SD)	74.2 (9.4)	51 – 91	70.2 (11.0)	50 – 97
ESR, mean (SD)	78.4 (30.3)	22 – 120	39.9 (32.4)	2 – 124
Missing	3		9	
CRP, mean (SD)	74.7 (60.0)	2 – 283	35.8 (52.9)	0.4 – 280
Missing	1		6	
Polymyalgia Rheumatica, % yes (n)	21 (13)		11.8 (17)	
Cranial symptoms, % yes (n)	80.6 (50)		75.0 (108)	
Vision loss, %yes (n)	27.4 (17)		15.3 (22)	
Compliant with GCA (i.e. AION, central retinal artery occlusion diplopia)				
Diagnostics				
CDUS* %yes (n)	96.8 (60)		96.5 (139)	
TAB** %yes (n)	58.1 (36)		18.8 (27)	
PET/CT***yes (n)	40.3 (25)		16.0 (23)

Figure 1. Description of consultation (A); referral (B); diagnostic (C) and total (D) delay in weeks for controls (black) and GCA patients (green), stratified for C-GCA (red), LV-GCA (blue) and C/LV-GCA (purple). ¹Not possible for controls as no GCA-indicated treatment was started.

Disclosure of Interests: None declared

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AB0368 CLINICAL CHARACTERISTICS AND RADIOGRAPHIC OUTCOME OF VASCULAR BEHCET'S DISEASE INVOLVING AORTA AND ITS MAJOR BRANCHES

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Background: Behcet's disease (BD) is an immune-mediated systemic vasculitis affecting any size of blood vessels. Previous studies showed that BD may involve large arterial vessels [1] but the radiographic outcome has not been well known due to its low prevalence.

Objectives: To evaluate the radiographic outcome of vascular BD involving aorta and its major branches and the clinical characteristics of each prognosis group.

Methods: We retrospectively analyzed the medical records of patients who visited a single-center tertiary hospital in Seoul, Korea, across a 19-year period (Jan 2002 to Dec 2020). All patients fulfilled the International Criteria for Behcet's Disease. The patients included in this study had undergone CT angiography (CTA) of the aorta and its major branches at least twice in a 2–5 year interval and showed characteristic vascular involvements (aneurysm, stenosis, occlusion, vessel wall thickening, and thrombosis). Due to lack of the validated definition of radiographic progression of large vessel vasculitis in BD, we defined 20% changes of existing lesions or occurrence of new lesions as a radiographic progression.

Results: 22 patients with BD met the inclusion criteria. 5 patients (22.7%) progressed radiographically between the initial and follow-up CTA despite low acute

phase reactant levels (AUC of ESR and CRP were 13.94 mm/h and 0.32 mg/dl, respectively). Aneurysm was the most frequent form of vascular involvement followed by thrombosis (21 [95.5%] and 11 [50.0%] patients, respectively, Table 1). Patients with radiographically progressive disease had longer disease duration (1.63 vs. 6.61 years, $p=0.010$) at initial CTA evaluation. Other clinical characteristics, including ESR, CRP, medication use, and follow up duration, were not different between two groups (Table 2).

Table 1. Radiographic characteristics of the cohort.

	Overall	Not progressed	Progressed	
n	22	17	5	p
Aneurysm (%)	21 (95.5)	16 (94.1)	5 (100.0)	>0.999
Stenosis (%)	5 (22.7)	4 (23.5)	1 (20.0)	>0.999
Occlusion (%)	5 (22.7)	5 (29.4)	0 (0.0)	0.440
Wall thickening (%)	4 (18.2)	4 (23.5)	0 (0.0)	0.589
Thrombosis (%)	11 (50.0)	9 (52.9)	2 (40.0)	>0.999

Conclusion: A considerable number of vascular BD patients involving aorta and its major branches progressed radiographically despite low disease activity. Radiographically progressed patients had longer disease duration, but other clinical characteristics were not significantly different whether progressed or not.

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Table 2. Clinical characteristics of the cohort.

	Overall	Not progressed	Progressed	
n	22	17	5	p
Sex (Male) (%)	22 (100.0)	17 (100.0)	5 (100.0)	NA
Age (yr)	46.43 (7.71)	45.06 (8.06)	51.10 (4.03)	0.126
Disease duration (yr)	2.77 (3.99)	1.63 (2.66)	6.61 (5.61)	0.01
HTN (%)	5 (22.7)	4 (23.5)	1 (20.0)	>0.999
DM (%)	1 (4.5)	1 (5.9)	0 (0.0)	>0.999
Dyslipidemia (%)	6 (27.3)	5 (29.4)	1 (20.0)	>0.999
CKD (%)	7 (31.8)	4 (23.5)	3 (60.0)	0.321
BMI (kg/m ²)	42.91 (91.28)	48.23 (103.94)	24.82 (1.69)	0.626
AUC of CRP (mg/dl)	0.32 (0.37)	0.31 (0.41)	0.37 (0.12)	0.758
AUC of ESR (mm/h)	13.94 (11.40)	13.30 (12.77)	16.12 (4.66)	0.638
Immunosuppressive agent use (%)	18 (81.8)	14 (82.4)	4 (80.0)	>0.999
Steroid use (%)	22 (100.0)	17 (100.0)	5 (100.0)	NA
f/u duration (yr)	3.54 (0.80)	3.56 (0.79)	3.50 (0.92)	0.885

Data are presented as mean (SD) unless otherwise specified

Disclosure of Interests: None declared

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AB0369 EVALUATION OF BASELINE POSITRON EMISSION TOMOGRAPHY IN THE DIAGNOSIS AND ASSESSMENT OF GIANT CELL ARTERITIS

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Background: Positron emission tomography (PET/CT) has gained importance in the diagnosis and assessment of large vessel vasculitis (LVV) recently.

Objectives: We aimed to investigate the diagnostic importance and clinical significance of PET/CT findings in giant cell arteritis (GCA).

Methods: Data of the patients who underwent PET/CT to investigate large vessel involvement and who had at least 6 months of follow-up with a clinical diagnosis of GCA were retrospectively evaluated. PET/CT images were assessed by an experienced nuclear medicine specialist, regions of interest were drawn for major vascular territories and standardized maximum uptake values (SUVmax) of these areas were recorded.

Results: Twenty-nine consecutive patients (median age 68 (50-83), mean follow-up time 37.1 ± 48.8 (6-242)) were included into the study. All patients were over 50 years old and had erythrocyte sedimentation rate (ESR) over 50 mm/h at the time of imaging. Twenty patients (68.9%) met the ACR 1990 Classification criteria (ACR (+) group). The number of patients who had hypermetabolism in the aorta and its major branches in favour of LVV in PET/CT was 23 (79.3%) (PET-CT (+) group). Thoracic and abdominal aorta involvement were detected in 22 (75.8%) and 16 (55.2%) patients, respectively. There was positive correlation