SOBI, Consultant of: Abbvie, Amgen, Biogen, BMS, Celltrion, Galapagos, Glaxo SmithKline, Novartis, Pfizer, Roche, Sanofi-Genzyme, SOBI; clinical trial for Kiniksa, Grant/research support from: Abbvie, Amgen, BMS, Celltrion, Galapagos, Novartis, Pfizer, Roche, Sanofi-Genzyme, SOBI, Merk Sharp & Dohme, Janssen, Kiniksa, Bhaskar Dasgupta Paid instructor for: Educational grant symposium/workshop for Roche-chugai, Sanofi, and Abbvie, Consultant of: CI UK for the Kiniksa trial, Grant/research support from: Educational grant symposium/workshop for Roche-chugai, Sanofi, and Abbvie, Bernhard Hellmich Consultant of: Honoraria paid to the institution for participation in the clinical trial, Eamonn Molloy: None declared, Carlo Salvarani: None declared, Bruce C. Trapnell Consultant of: Consultant member of DSMB for Kiniksa., Kenneth J Warrington Consultant of: Clinical trial support from Eli Lilly and Kiniksa, Ian Wicks: None declared, Manoj Samant Shareholder of: Kiniksa Pharmaceuticals, Employee of: Kiniksa Pharmaceuticals, Teresa Zhou Shareholder of: Kiniksa Pharmaceuticals, Employee of: Kiniksa Pharmaceuticals, Lara Pupim Shareholder of: Kiniksa Pharmaceuticals, Employee of: Kiniksa Pharmaceuticals, John F. Paolini Shareholder of: Kiniksa Pharmaceuticals, Employee of: Kiniksa Pharmaceuticals
DOI: 10.1136/annrheumdis-2021-eular.2221

AB0371

PATIENTS WITH PROLONGED SYMPTOMS BEFORE GCA DIAGNOSIS DO NOT INCUR HIGHER RATES OF VISUAL LOSS

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Background: Giant cell arteritis (GCA), if left untreated, confers the threat of serious cranial ischaemic complications including permanent visual loss. Although achieving a prompt and accurate diagnosis remains challenging, early diagnosis is viewed as being paramount in preventing significant morbidity.¹ This raises the question of whether GCA patients are at greater risk of developing visual sequelae if there is a longer window between symptom onset and presentation.

Objectives: To compare the frequency of lasting visual loss in patients diagnosed with GCA undergoing temporal artery biopsy (TAB) within three months and after three months of symptom onset.

Methods: Patients who underwent TAB from January 2011 to November 2020 were identified from the pathology database of an Australian rheumatology referral centre. The diagnosis of GCA was established for each patient based on either positive TAB or, in the setting of negative TAB, clinical diagnosis by a rheumatologist. Baseline demographics, symptoms and major confounders – including age, sex, history of polymyalgia rheumatica or inflammatory arthritis, headache, jaw pain, fatigue, temporal artery tenderness or diminished pulse, and number of 1990 American College of Rheumatology (ACR) classification criteria for GCA² fulfilled – were manually extracted from electronic medical records, as was the duration between onset of GCA symptoms and TAB, and the presence of visual loss before and after TAB. Logistic regression log-likelihood tests were used to examine the two cohorts presenting before and after three months.

Results: There were 167 patients who underwent TAB during the study period with accessible clinical information. Of these, 31 (19%) had a delayed presentation of greater than three months from symptom onset. There were no statistical differences in patient demographics between the two groups (Table 1). No patients with delayed presentation experienced lasting, objective visual loss. In contrast, there were three cases in the cohort of patients who presented more promptly; these included two patients who developed permanent unilateral blindness, and one who experienced unilateral vision loss with some improvement at three months of follow-up.

Table 1. Patient characteristics by time from symptom onset to TAB.

	Presentation <3 months	Presentation ≥3 months	p-value
Age (years)	73.45±10.06	69.84±10.75	0.080
Female	92 (67.65%)	20 (64.52%)	0.738
History of polymyalgia rheumatica	23 (16.91%)	4 (12.90%)	0.586
History of inflammatory arthritis	6 (4.41%)	2 (6.45%)	0.633
Headache	110 (80.88%)	23 (74.19%)	0.406
Jaw pain	37 (27.21%)	5 (16.13%)	0.206
Fatigue	28 (20.59%)	6 (19.35%)	0.878
Temporal artery tenderness or diminished pulse	46 (33.82%)	11 (35.48%)	0.860
ACR classification criteria	2.83±0.99	2.58±0.89	0.199

Conclusion: GCA patients with a lengthier course of symptoms before diagnosis did not experience any enduring visual loss. This may reflect a pattern of more aggressive disease leading to earlier presentation, but further study should explore whether longer symptom duration before diagnosis necessitates a higher degree of clinical concern.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.2234

AB0372

TOCILIZUMAB WAS EFFECTIVE IN REFRACTORY ARTERIAL INVOLVEMENT OF BEHCET'S DISEASE: A REAL-LIFE SINGLE-CENTER EXPERIENCE IN CHINA

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Background: Behcet's disease (BD) is a chronic and relapsing vasculitis, in which major vessel involvement is a main cause of mortality and morbidity. The therapeutic arsenal is mainly composed of classical immunosuppressants. However, when faced with resistance to these drugs, no alternative therapeutic strategy is currently recommended.

Objectives: To assess the efficacy and safety of interleukin 6 receptor inhibitor tocilizumab (TCZ) in refractory arterial involvement of BD in a real-life observational setting.

Methods: 10 patients were enrolled in our center between 2014 and 2019. All patients met the international criteria for BD and had severe arterial involvement evaluated by echocardiography, angio-Computerized Tomography scan and vascular Doppler. The diagnosis of refractory arterio-BD was based on objective vascular symptoms not explained by any other known disease and non-response to conventional immunosuppressants combined with glucocorticoids therapy. All patients underwent TCZ infusions at 8mg/kg every 4 weeks. Concomitant therapy with immunosuppressants and glucocorticoids was continued. Clinical and imaging findings were assessed before and after TCZ therapy. All adverse events were recorded during follow-up.

Results: All the patients were males, with a mean age of 44.3±10.5 years in this study. The mean age at presentation of arterial involvement was 40.8±9.2 years old. The patterns of arterial involvement were aneurysm (n=9), stenosis (n=3) and aortic valve lesion (n=2). After a mean follow-up of 26.8±7.2 months, TCZ yielded rapid and maintained clinical improvement in 9 patients, with complete remission in 6 of them and partial response in 3 of them. Discontinuation of TCZ treatment due to relapse occurred in one case as the enlargement of abdominal aortic aneurysm. The mean glucocorticoid dosage was tapered from 54.5±20.6mg/d to 8.3±3.6mg/d (p<0.001). And the use of immunosuppressants was tapered in 4 (40.0%) patients. As for serological improvement, the median ESR and CRP levels decreased from 50 (2-82) mm/h and 32.9 (2.1-62.3) mg/dL to 4 (1-10) mm/h (p<0.001) and 2.9 (0.2-12.1) mg/dL (p<0.001), respectively. Radiologic improvement of artery lesion was demonstrated in 4(40%) patients. None of the patients had serious adverse events during follow-up.

Conclusion: TCZ was a safe and effective therapeutic option for refractory arterial involvement of BD, with a favorable steroid-sparing effect.

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