Table 1. Characteristic of the patients.

Nº Patients	19
Female	6 (31.5%)
Male	13 (68.4%)
Age median	64 (IQR18)
Ethnicity	
Black	4 (21.05%)
Caucasian	15 (78.9%)
Comorbidities	
Diabetes mellitus type 2	2 (10.5%)
Hypertension	12 (63.1%)
Obesity	5 (26.3%)
Hypercholesterolemia	9 (47.3%)
Smoker	6 (31.5%)
Nº (%) patients with prednisone ≤ 5 mg at end of follow-up according to treatment received	
Only steroids (5)	1 (20%)
Steroids + methotrexate (12)	10 (83.3%)
Steroids + mycophenolate (2)	1 (50%)

REFERENCES:

- [1] Cinar, I., Wang, H., & Stone, J. R. (2017). *Clinically isolated aortitis: pitfalls, progress, and possibilities*. *Cardiovascular Pathology*, 29, 23–32.

Disclosure of Interests: None declared

Figure 1.

DOI: 10.1136/annrheumdis-2021-eular.3373

AB0378

UTILITY AND ACCURACY OF SOUTHERN PRETEST PROBABILITY SCORE IN GCA FAST-TRACK CLINIC: ANALYSIS IN 261 CONSECUTIVE PATIENTS

J. Ortega¹, I. Monjo², E. Fernández-Fernández², E. De Miguel^{1,2}. ¹Universidad Autónoma Madrid, Rheumatology, Madrid, Spain; ²University Hospital La Paz, Rheumatology, Madrid, Spain

Background: Strategies for early diagnosis of Giant Cell Arteritis (GCA) have been implemented in the last decade in order to reduce the occurrence of blindness, ischemic events and other manifestations of the disease. The Southern pretest probability score (SPTPS) ¹ seem to be useful in stratifying and select the referral patients sent to the GCA fast-track clinics.

Objectives: The aim of this study was to test the validity and utility of this score in our patients.

Methods: Retrospective available data records of all the patients referred to our GCA fast-track clinic in the last three years were collected. The clinical and laboratory features at referral were evaluated, and the SPTPS was generated. All patients had ultrasound of cranial and large vessel examination (axillary, subclavian and carotid arteries). GCA diagnosis was confirmed by the doctor after at least six months of follow-up. Quartile frequencies, ROC curves and accuracy of the SPTPS was calculated.

Results: 261 patients (180 females) with suspicions of GCA were evaluated in our fast-track clinic. Mean age (±SD) was 76±9.2 years, and C-reactive protein 75.7±68.6 mg/l. The time since the first symptoms was less of 6, 6-12, 12-24 or >24 weeks in 37.5%, 19.9, 12.3 and 15.7 respectively. Mean SPTPS was 11.4±4.4, with values of 9.1±3.2 and 12.9±4.4. The area under the ROC curve was 0.761 (95% confidence interval: 0.703-0.819). PTPS overall showed a 50th percentile score of 11 and a 75th percentile score of

14. We, therefore, classified "Low Risk" (LR) as SPTPS <11, "Intermediate Risk" (IR) 11–14 and "High Risk" (HR) >14. Of 261 referrals, 156 had GCA with cases categorised as LR (119), IR (91) and HR (51). HR score showed a specificity of 96.2% and in IR the specificity ranged between 86.7 and 94.3% (Table 1). Score below 7 appears in 29 cases with only 8 cases of GCA with a probability of GCA < 5%, more of these cases was associated a large vessel vasculitis: 3 cranial arteritis (CA), 4 large vessel vasculitis (LVV) and 1 mixed pattern (MP). LR score included 72 of the 105 (68.6%) non-GCA cases but 47 of 156 (30.1%) GCA patients (20 CA, 11 LVV and 16 MP). IR risk score included 26 (24.8%) of the non-GCA cases and 65 (41.7%) of GCA patients (31 CA, 13 LVV and 21 MP). Finally HR score had only 7 non-GCA cases and 44 (28.2%) patients with GCA (20 CA, 11 LVV and 13 MP). Mean score in cranial forms was 13.1±4.5 and in large vessel vasculitis 12.8±5.0 (p=0.807).

Table 1. Sensitivity and Specificity of SPTPS at different cut-off points

Cut-off point	Sensitivity	1-Specificity
2	1.000	1.000
3.5	0.994	0.971
4.5	0.987	0.943
5.5	0.987	0.876
6.5	0.949	0.790
7.5	0.897	0.676
8.5	0.846	0.476
9.5	0.750	0.362
10.5	0.679	0.248
11.5	0.538	0.133
12.5	0.449	0.086
13.5	0.353	0.057
14.5	0.218	0.038
15.5	0.147	0.019
16.5	0.128	0.019
17.5	0.077	0.010
19	0.038	0.000
20.5	0.032	0.000
21.5	0.019	0.000
22.5	0.013	0.000
24	0.000	0.000

Conclusion: The SPTPS is helpful to stratified patients sent to the fast-track clinic. Scores below of 7 points has a very low probability to have GCA. The diagnostic probability increases directly with the score. There were minor differences without statistical significance between cranial or large vessel vasculitis patterns in the score.

REFERENCES:

- [1] Sebastian A, Tomelleri A, Kayani A, Prieto-Pena D, Ranasinghe C, Dasgupta B. Probability-based algorithm using ultrasound and additional tests for suspected GCA in a fast-track clinic. *RMD Open*. 2020 Sep;6(3):e001297. doi: 10.1136/rmdopen-2020-001297. PMID: 32994361; PMCID: PMC7547539.

Disclosure of Interests: Javier Ortega: None declared, Irene Monjo Speakers bureau: Roche, Novartis, UCB, Gedeon Richter, Consultant of: Roche, Elisa Fernández-Fernández: None declared, Eugenio de Miguel Speakers bureau: AbbVie, Novartis, Pfizer, MSD, BMS, UCB, Roche, Grunental, Janssen, Sanofi., Paid instructor for: Janssen, Novartis, Roche, Consultant of: AbbVie, Novartis, Pfizer, Galapagos, Grant/research support from: Abbvie, Novartis, Pfizer

DOI: 10.1136/annrheumdis-2021-eular.3385

AB0379

BARICITINIB IN POLYMYALGIA RHEUMATICA AND GIANT CELL ARTERITIS: REPORT OF SIX CASES

D. Camellino¹, C. DeJaco^{2,3}, A. Giusti¹, F. Martini⁴, R. Cosso⁵, G. Girasole¹, G. Bianchi¹. ¹Local Health Trust 3, Genoa, Division of Rheumatology, Department of Medical Specialties, Genoa, Italy; ²Medical University Graz, Department of Rheumatology, Graz, Austria; ³Hospital of Bruneck (ASAA-SABES), Department of Rheumatology, Bruneck, Italy; ⁴Local Health Trust 1, Medical Department, Sanremo, Italy; ⁵Local Health Trust 3, Medical Department, Genoa, Italy

Background: Glucocorticoids (GC) are the cornerstone of the treatment of polymyalgia rheumatica (PMR) and giant cell arteritis (GCA), but they are associated with several adverse events (AEs). Moreover, a considerable proportion of patients relapse during GC tapering.

Objectives: To describe the efficacy and safety of the JAK-inhibitor baricitinib (BARI) in a group of patients with PMR and/or GCA.