11 (9.1%) had been EMEUNET members for less than 2 years, 81 (66.9%) for 2-5 years and 29 (24.0%) for more than 5 years. Figure 2 shows a clear link between the respondents' perception of EMEUNET aim(s) and the actual aims of EMEUNET set out in our mission statement (https://emeunet.eular.org/mission_statement.cfm).

Figure 2. The links between what participants would like to see as EMEUNET aims and the aims of EMEUNET as they are now

Most of the respondents got to know about EMEUNET through a friend/colleague in Rheumatology ($n=67$, 54.0%), at EULAR/ACR annual conferences ($n=32$, 25.8%), via social media ($n=9$, 7.3%), other international meeting ($n=6$, 4.8%), national Rheumatology meeting ($n=6$, 4.8%) or via the EMEUNETs country liaisons ($n=4$, 3.2%).

29 respondents (24%) were part of the EMEUNET working group (WG), 43% ($n=53$) applied before to be part of the WG, 24% ($n=29$) never applied and 15% ($n=19$) did not know what the WG was. Most of the respondents who never applied to the WG thought it to be too time consuming. Only 21 (16.9%) felt there was a subgroup in the WG missing and most of those ($n=8$, 38.1%) found this should fully focus on research collaborations, which is actually part of the general aims of EMEUNET and a focus of all Working Groups.

Only a relatively small portion of EMEUNET of respondents (<5%) stated to have approached EMEUNET with their ideas. Although 90.2% ($n=110$) felt that the opportunity to submit new ideas is a good initiative, only 52.5% ($n=66$) knew that such possibilities exists. This suggests that EMEUNET could do more to make members aware of this possibility. Additionally, while the main reasons for not contacting EMEUNET with an idea were 'not having one' (41.9%) or having 'no time' (34.9%), 20.9% feels their ideas would not be received well, which is another aspect offering room for improvement.

Twice a year, EMEUNET organises networking events (NE) for their members to discuss their work in an informal setting. We found that 56/120 (46.7%) of the respondents prefer a low-budget (<€20) event, including an activity and the possibility to network, accompanied by drinks and bites. This is much in line with EMEUNETs past NE. In addition, past NEs were often mentioned as an example of ideal events.

Conclusion: Awareness on EMEUNET often comes from colleagues and international conferences in rheumatology, which coincides with one of the focuses of EMEUNET to increase visibility in the last 10 years. Expectations about NE are in line with the previously organised NE.

Areas for improvement are dissemination of information on the EMEUNET WG, the possibility to submit ideas -which is open to all members- and the increased focus on research collaboration, an aspect on which we are actively working as EMEUNET is fully engaged with the newly launched EULAR Virtual Research Centre.

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OP0078

HIGH MEDIAN NERVE LESION SECONDARY TO SEVERE GIANT CELL ARTERITIS (GCA)

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Background: Giant cell arteritis (GCA) is a systemic vasculitis affecting large to medium-sized vessels. Cranial nerve lesions are frequently documented secondary to GCA, however peripheral nerve are rarely involved.

Objectives: We present an unusual case of a GCA-associated isolated high median nerve palsy.

Methods: Case report.

Results: A 76 year old white British female presented in Spain with three weeks of frontotemporal headaches, mandibular claudication, photopsia and constitutional symptoms, followed by acute-onset right hand paresis and dysaesthesia. Acute-phase reactants were elevated. COVID-19 PCR was negative. Shortly after admission she developed acute bilateral anterior ischaemic optic neuropathy and tongue necrosis with autoamputation. Temporal artery ultrasound and biopsy confirmed GCA. PET-CT showed no evidence of a diffuse large-vessel vasculitis. She was repatriated to the UK for ongoing inpatient care. Upper limb neurophysiology two months later demonstrated an isolated right high median nerve lesion, with reduced median motor responses and absent sensory responses with denervation in extensor carpi radialis. Imaging excluded a central lesion. The timing of her symptoms suggested the lesion was secondary to GCA. Treatment was with tocilizumab, methotrexate and tapering corticosteroids, alongside PEG feeding and careful multi-disciplinary rehabilitation.

Conclusion: We suggest there are two important learning points from this complex case. Firstly, peripheral nerve lesions can occur in GCA, although they are rare. A literature search identified a modest number of case reports of brachial plexus or lower cervical nerve lesions^{1,2}. Neurologic manifestations in GCA are attributed to vasculitis of the vasa nervorum, or extension of inflammation from arteries to contiguous nerves^{1,2}. The restriction of clinical involvement to the median nerve alone would appear to favour the former mechanism. Functional recovery of neurological deficits is typically partial at best.

Secondly, this case highlights the difficulty faced by clinicians in recognising GCA and the importance of urgent treatment with glucocorticoids. The patient developed GCA during the ongoing COVID-19 pandemic when Spain was the second-worst affected European country (5% seroprevalence; 95% CI 4.7-5.4)³. The partial overlap in symptoms between GCA and COVID-19 (e.g. headache, pyrexia, malaise, elevated acute-phase reactants) can cause diagnostic confusion and treatment delay⁴. GCA should be considered in the differential diagnosis of older patients with suspected COVID-19, or the non-specifically unwell elderly patient.

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Table 1.

Area/movement	Result
Abductor pollicis brevis	Grade 2 weakness
Opponens pollicis	Grade 4 weakness
Pronator teres/quadratus	Grade 4 weakness
Flexor pollicis longus	Grade 1-2 weakness
Flexor digitorum profundus (digit 2 and 3)	Grade 1-2 weakness
Finger abduction	Preserved
Finger extension	Preserved
Other comments	
Dysaesthesia in distribution of median nerve	

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