(SAEs) following treatment with TCZ, corticosteroid dose before and following TCZ initiation and imaging data following TCZ treatment. Results are presented for the studies (unweighted) and as the weighted population mean. Unweighted mean proportions were calculated as the average of the proportions reported from each study; unweighted means were calculated by computing the mean of individual reported study means. The weighted population proportion was estimated by calculating the total number of patients achieving an outcome and dividing by the total number of patients in all of the studies. The weighted population mean was equivalent to the sum of the individual patient's outcome values divided by the total number of patients in all of the studies.

Results: The search retrieved 664 references; 55 full-text articles were reviewed for eligibility, and 36 studies were included in the meta-analysis (Figure 1); the once-weekly and every-2-weeks subcutaneous (SC) TCZ arms of the GiACTA trial were counted as separate studies. A total of 519 patients were included. The median (IQR) duration of treatment with intravenous and SC TCZ was 26.0 (20.0-37.3) and 52.0 (26.0-52.0) weeks, respectively, across all studies in the unweighted analysis and 25.8 (20.8-41.9) and 38.9 (32.4-45.5) weeks in the weighted analysis. The mean (SE) proportion of patients achieving investigator-defined remission at the end of the study was 86.3% (4.3%) and 79.3% (6.0%) in the unweighted and weighted analyses, respectively (Table 1). The mean (SE) proportion of patients who relapsed while receiving TCZ was 2.6% (1.3%) and 12.0% (4.5%) in the unweighted and weighted analyses, respectively. The median prednisone dose at the end of the study was < 5 mg/day, and the mean proportion of patients with SAEs after TCZ initiation was ~ 14.0%.

Conclusion: A high proportion of patients with GCA treated with TCZ were in investigator-defined remission at the end of the study across all studies analyzed. These meta-analysis findings add to the evidence of the efficacy and safety of TCZ in GCA.

Figure 1. Study Types Included in Meta-Analysis

*The subcutaneous TCZ once-weekly and every-2-weeks treatment arms of the GiACTA trial were counted as separate studies.

Table 1. Summary of Remission, Relapse and Adverse Events

Mean (SE) [95% CI]	Across GCA Studies; Unweighted (n = 36 studies)	Weighted Population Mean (n = 519 patients)
Percentage of patients in investigator-defined remission at the end of the study	n=35 86.3 (4.3) [77.6 to 94.9]	n=411 79.3 (6.0) [67.2 to 91.4]
Percentage of patients who relapsed while receiving TCZ	n=31 2.6 (1.3) [-0.18 to 5.3]	n=39 12.0 (4.5) [2.8 to 21.2]
Percentage of patients who relapsed after TCZ discontinuation	n=20 26.4 (7.8) [10.1 to 42.7]	n=41 14.8 (5.8) [2.7 to 26.9]
Percentage of patients receiving no steroids at the end of follow-up	n=31 41.8 (6.8) [27.8 to 55.8]	n=170 49.4 (8.1) [32.8 to 66.0]
Percentage of patients with SAEs after TCZ initiation	n=35 14.0 (4.1) [5.5 to 22.4]	n=72 14.3 (1.3) [11.7 to 17.0]

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POS0800

VISUAL ISCHEMIA DURING RELAPSE AND FOLLOW-UP OF GIANT CELL ARTERITIS: A SYSTEMATIC REVIEW

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Background: Visual ischemia (VI) is one of the most feared complications in giant cell arteritis (GCA). While the frequencies of VI development at or near diagnosis are better studied, limited information is available regarding the frequency of VI during relapse.

Objectives: The purpose of this study was to characterize the frequency of visual ischemia (VI) as a manifestation of relapse or during follow-up in patients with GCA through performance of a systematic literature review.

Methods: Potentially eligible studies were identified from Medline and EMBASE databases from inception to November 31, 2019 using a search strategy that comprised of terms for "giant cell arteritis," "temporal arteritis," or "Horton's disease," with "relapse," "recurrence," "flare," "outcome," "follow-up," or "prognosis." VI was defined as transient or permanent, full or partial, monocular or binocular visual field loss. VI occurring within 4 wks of GCA diagnosis was considered due to active disease and not included as a relapse event. Inclusion criteria used: (1) original research reported in English, (2) GCA definition provided, (3) VI outcome described as one of the following: (a) relapse rate/frequency denoting the presence or absence of VI, or (b) absolute number of VI events (> 4 weeks after GCA diagnosis) even if total cohort relapse rate/frequency was not provided. In order to reduce bias from under-reporting of negative results, studies that reported relapse rates/frequencies with accompanying relapse characteristics but did not provide initial detail regarding the presence/absence of VI were also identified. In such circumstances, the primary authors were directly contacted for patient-level data regarding VI and these studies were included in the final analysis if such data were available and provided.

Results: A total of 913 unique articles were identified and underwent screening. Among these, 148 articles underwent independent full-text review by two physicians (K.B. and M.J.K.). 33 articles met full inclusion criteria and an additional 21 articles included data on relapse but did not report VI patient data in the publication. Responses were received from authors of 11 of these 21 studies allowing for inclusion. 44 studies accounting for 3,649 patients with GCA were identified. Average percentage of baseline VI was 19% (range 0-66%). The average length of follow-up was 3.4 years (range 0.4 to 8.7). VI developing > 4 weeks after GCA diagnosis was recorded in a total of 53 patients (1.5%).

Study-defined relapses were reported in 36 studies. A total of 1,215 patients with at least one or more relapses were recorded among 2,592 patients under observation (47%). Among these 36 studies, VI occurred in 37 patients (3.0%) with at least one study defined relapse event.

Comparing trial design, retrospective studies (n=25) reported 27 of 2,718 (1%) patients developed VI during follow-up whereas 19 of 541 (3.5%) patients in randomized controlled trials (n=8) developed VI during the trial or post-trial follow-up.

Conclusion: This report outlines the first systematic review evaluating VI as a manifestation of relapse and during follow-up in GCA. Overall, VI > 4 weeks after GCA diagnosis is uncommon (1.5%) but is noted in up to 3% of patients with at least one relapse event. Frequencies of reported VI were 3.5 times higher in randomized controlled trials compared to retrospective studies.

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POS0801

VASCULITIS IN PATIENTS WITH SARCOIDOSIS: A SINGLE-INSTITUTION CASE SERIES OF 17 PATIENTS

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