was evaluated, using erythrocyte sedimentation rate (ESR) as a reference. Disease activity assessment models were constructed and concordance index (C-index), net reclassification index (NRI), and integrated discrimination index (IDI) were evaluated to compare the benefits of the new modes with ESR and Kerr score.

Results: In total, 64 (70.3%) cases showed active disease. Higher levels of ESR and CRP, and lower interleukin (IL)-2R levels, were observed in active cases. 18F-FDG-PET/CT parameters, including SUVmean, SUVratio1, SUVratio2, sum of SUVmean, and sum of SUVmax, were significantly higher in active disease groups. The C index threshold of ESR to indicate active disease was 0.78 (95% CI: 0.69-0.88). The new activity assessment model combining ESR, sum of SUVmean, and IL-2R showed significant improvement in C index over the ESR method (0.96 vs. 0.78, $P < 0.01$; NRI 1.63, $P < 0.01$; and IDI 0.48, $P < 0.01$). The new model also demonstrated modest superiority to Kerr score assessment (0.96 vs. 0.87, $P = 0.03$; NRI 1.19, $P < 0.01$; and IDI 0.33 $P < 0.01$).

Conclusion: A novel 18F-FDG-PET/CT-based method that involves combining the sum of SUVmean with ESR score and IL-2R levels demonstrated superiority in identifying active TA compared to conventional methods.

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POS0818 TREATMENT OF POLYMYALGIA RHEUMATICA WITH TOCILIZUMAB: RESULTS OF AN OBSERVATIONAL RETROSPECTIVE MULTICENTER STUDY

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Background: In 2017, TOCILIZUMAB (TCZ) obtained marketing authorization for treatment of giant cell arteritis (GCA); however, this doesn't extend to polymyalgia rheumatica (PMR) therapy. Based on efficacy data for TCZ in GCA, TCZ is sometimes used as a glucocorticoid (GC) sparing agent when PMR is GC dependent or when a rapid steroid withdraw is needed. Currently, there are no available recommendations on the use of this therapeutic class in for this particular indication.

Objectives: Here, we present the results of an observational French multicentric study of patients with PMR treated with TCZ.

Methods: Thirteen medical centers were included in this study. The data was collected retrospectively between 2015 and 2020. The minimum duration of treatment was 3 months. Patients were included when receiving TCZ for isolated PMR or associated with a non-active GCA (asymptomatic, no vascular fixation on PET scanner).

Results: Overall, 34 patients were included (24 women; mean age 70.1 years (+/-10.3)). At TCZ introduction, patients had been treated with GC for a mean duration of 27.9 months (+/-25.9) and the mean GC dose was 16.8mg/d (+/-10). Fifteen patients (44%) had one or more complications from GC therapy. Another immunosuppressant was added before TCZ treatment for 25 (74%); mostly METHOTREXATE (24/25).

TCZ was initiated intravenously at 8mg/kg every 4 weeks for 27 patients (79%) and subcutaneously at 162mg/week for 7 patients (21%).

The reasons for TCZ introduction included GC dependence (n=30, 88%), and necessity of quick GC sparing (n=4 patients, 12%).

Of all patients, 76% (26 patients) had stopped GC treatment definitively, with a mean time of 9.4 (0-32) months.

The mean TCZ treatment period was 19.2 months (3-66). Fifteen patients (44%) permanently stopped TCZ at the end of the observation period (8 prolonged remissions; 1 myocardial infarction; 1 cutaneous lymphoma; 1 primary failure, 3 lost to follow up).

Eighteen patients (60%) benefited from an attempted tapering of TCZ (infusion spacing or dose reduction), 6 attempts (1/3) led to a relapse. 1/2 patients had side effects mostly benign (cytopenia n=6, infections n=5).

Conclusion: This is the largest cohort presenting results of the use of TCZ in PMR. Despite the small number of participants, our study suggests TCZ is effective as a GC sparing agent in PMR. As there are no official recommendations of use, indications for TCZ use within this population are not defined. Randomized Controlled Trial would be beneficial to validate these first results.

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POS0819 EMERGENCE OF DE NOVO MANIFESTATIONS DURING INFILIXIMAB TREATMENT IN BEHÇET SYNDROME

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Background: Infliximab (IFX) is increasingly used in the management of severe, relapsing or refractory manifestations of Behçet Syndrome (BS). Emergence of de novo manifestations have been reported during IFX treatment, despite efficacy for the initial manifestation that required IFX use¹.

Objectives: We aimed to survey a sizeable cohort of BS patients treated with IFX for the development of de novo manifestations during treatment.

Methods: A chart review was conducted to identify all BS patients who were given IFX in our Behçet Disease Research Center between 2004 and 2020. Demographic data, indications for IFX initiation, concomitant drugs, prior treatments, and outcomes were recorded. De novo manifestations were defined as new BS manifestations that had not occurred before IFX treatment.

Results: A total of 252 patients used IFX with the main indications being uveitis in 122, vascular involvement in 82, parenchymal central nervous system involvement in 32, gastrointestinal involvement in 11, arthritis in 10, mucocutaneous involvement in 4, and secondary amyloidosis in 1. Of these patients, 17 (6%) had developed a total of 21 de-novo manifestations during a mean follow-up of 38.4 ± 92 (SD) months (Table 1). Vascular involvement was the main indication for IFX in the majority (n=12; 71%) of these 17 patients followed by eye involvement (n=3; 18%), central nervous system involvement (n=1), and joint involvement (n=1). Concomitant medications were prednisolone in 14 patients, azathioprine in 6 patients, mycophenolate mofetil, cyclosporine-A and methotrexate in 1 patient each. Thirteen patients (76%) were in remission for the main indication when de-novo manifestations emerged. In 10 patients IFX treatment was intensified either by increasing the dose to