performed when deemed necessary by the responsible physician. TAB was performed in 86.5%, subclavian and carotid arteries. Other diagnostic tests were performed in 42.1%, 40 with GCA (22%) and 85 without (68%). The HR category included 67 patients (22.5%), 47 with GCA (70.1%). In 4 of the 7 patients with GCA, the CDUS was negative and the diagnosis was confirmed with PET-CT. On the other hand, 6 of the 200 included patients without GCA (3%) had a false positive result of CDUS.

There were 93 patients classified as LR with negative CDUS, and 1 of them had a final clinical diagnosis of GCA. Of the 46 patients classified as HR with positive CDUS, 1 was a false positive diagnosis of GCA. And, within the IR group, of the 84 patients with negative CDUS one had a final GCA diagnosis and of those with positive CDUS 2 were not GCA (Figure 1). Therefore, the combined use of SPTPS + CDUS only misclassified 5/297 cases (<2%).

REFERENCES:

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Figure 1. Kaplan-Meier plot of time to first GCA flare from baseline up to Week 52 (Full analysis set)

Conclusion: SEC demonstrated a higher sustained remission rate and longer time to first GCA flare vs PBO through 52 wks in pts with GCA. This proof-of-concept phase 2 study supports further development of SEC as a potential treatment in combination with 26 wk glucocorticoid taper for pts with GCA.