of glucocorticoids without flares for at least 1 year. All patients were followed according to a standardized predefined follow-up and therapeutic protocol. At the end of the follow-up period, we evaluated for each patient the number of flares, long-term remission, the duration of steroid treatment and the cumulative glucocorticoid dose.

**Results:** Association analysis of 3872G>A polymorphism showed that allele A homozygosity was significantly more frequent in cases than in healthy controls (OR = 2.32, 95% CI: 1.26-4.27, p = 0.006). Association analysis of 4741C>G polymorphism showed that allele G carried by GG and GG genotypes was significantly lower in GCA patients than in controls (OR = 0.35, 95% CI: 0.17-0.70, p < 0.002). No significant associations were found between these 2 polymorphisms and baseline clinical manifestations. Patients homozygous for the allele A had a significantly lower frequency of CRP values >5 mg/dl at diagnosis compared to patients carrying GA or GG genotypes (44.5% vs 72.4%, p = 0.018, OR 0.31, 95% CI: 0.11-0.85). Considering 4741G>C CRP gene polymorphism, patients carrying G allele had at diagnosis significantly higher levels of CRP (13.2±5.5 vs 8.9±6.3 mg/dl, p = 0.037) and ESR (105±30.6 vs 86.6±29.0 1st hour, p = 0.040), and lower levels of Hb (10.3±1.2 vs 11.3±1.5 g/dl, p = 0.044). At histological examination of temporal artery biopsy (TAB), patients homozygous for the allele A had significantly more frequent eosinophilic infiltration of the arterial wall (21.4% vs 6.0%, p = 0.010, OR 4.28, 95% CI: 1.31-13.98) than patients carrying allele G. Furthermore, patients carrying the allele A had lower steroid treatment duration (52±56 vs 79±78 months, p = 0.041), lower cumulative steroid dose (11146±7162 vs 18520±19659 mg, p = 0.017), higher frequency of steroid treatment withdrawal (61.5% vs 39.6%, p = 0.016) and of longterm remission (60.3% vs 39.6%, p = 0.024). Survival analyses demonstrated a significant difference for the duration of steroid treatment and the frequency of long term remission between the three AA, AG and GG genotypes (p=0.033 and p=0.031 respectively).

**Conclusion:** Single nucleotide polymorphisms of PCR gene at position 3872G/A (rs2015) and 4741G>C (rs3093068) have impact on susceptibility and outcomes of biopsy-proven GCA.

**REFERENCES:**

**Disclosure of Interests:** None Declared.

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**AB0727**

A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED, PARALLEL GROUP STUDY TO EVALUATE THE EFFICACY OF METHOTREXATE AS REMISSION MAINTENANCE THERAPY AFTER REMISSION-INDUCTION THERAPY WITH TOCILIZUMAB AND GLUCOCORTICOIDS IN SUBJECTS WITH GIANT CELL ARTERITIS (METEORITICS TRIAL): STUDY PROTOCOL

**Keywords:** Disease-modifying drugs (DMARDs), Vasculitis, Clinical trials

**Background:** Giant cell arteritis (GCA) is the most common systemic vasculitis found in adults over 50 years of age and affects medium and large vessels. The standard treatment is glucocorticoids (GC). Because of the negative side effects of GC and the high prevalence of relapses GC should be combined with other immunosuppressive or immunomodulatory agents. Since the GACTA Trial and other randomized controlled trials (RCT) assigned tocilizumab (TCZ) a GC-sparing effect, higher remission rates compared to placebo and the potency to maintain remission even without GC this biologic is a promising option to treat GCA. Due to the high costs of the TCZ treatment and the increased risk of infections, other treatment options are needed in the long term. An RCT published by Adler et al. showed that only 55% of patients remained in remission after discontinuation of intravenous TCZ therapy. It highlights the need for options to maintain remission after discontinuation of TCZ. The combination of methotrexate (MTX) and GC was also effective in reducing relapse rate and the cumulative GC doses in new or relapsing GCA.

**Objectives:** The primary objective of the study is to investigate whether MTX is useful in maintaining remission after remission-induction with TCZ and GC in patients with GCA. In addition, we evaluate patient and investigator reported outcomes, prevalence of aortitis, number of vasculitic vessels and change of intima-media-values during the study.

**Methods:** This monocentric, randomized, double-blind, placebo-controlled study estimates the efficacy of MTX through a treatment period of 12 months and a six-months follow-up. Patients who are in stable remission after treatment with GC and at least six months of treatment with TCZ for new-onset or relapsing giant cell arteritis are eligible for inclusion. Forty participants will be randomly assigned to the treatment arm (N=20) and the placebo arm (N=20). The treatment consists of 175 mg MTX subcutaneous weekly for 12 months as a monotherapy. In case of intolerance, elevated liver enzymes or low glomerulaturation rate a dose reduction is possible. In event of relapse an escape treatment with GC on a tapering regimen is added to the study medication. Assessments are conducted eight times during the treatment period and twice during the follow-up. An ultrasound examination takes place on every study visit to measure the intima-media-values of several arteries. Magnetic resonance imaging is performed on baseline, month 12 and 18 to detect aortitis. The primary endpoint is the time to first relapse during the 12 months therapy.

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**Disclosure of Interests:** None Declared.

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**AB0728**

AORTITIS SPECTRUM, STUDY OF 82 PATIENTS FROM A SINGLE REFERRAL CENTER

**Keywords:** Real-world evidence, Vasculitis

**Background:** Aortitis is the inflammation of the aortic wall, and can be idiopathic or associated with a cluster of infectious and non-infectious diseases. Giant-cell arteritis (GCA) and Takayasu arteritis (TA) are the most common underlining [1,2].

**Objectives:** To assess the causes and the main features of patients with aortitis.

**Methods:** Observational study of patients with aortitis from a large-vessel vasculitis monographic consultation at a referral hospital from June 2022 to December 2022. Aortitis was diagnosed by imaging techniques.

**Results:** We present 82 patients (52 female/30 male) mean±SD age; 60.2±12.6 years). The different subtypes of aortitis were: GCA (n=69), Takayasu arteritis (n=6), other inflammatory autoimmune diseases (n=3), IgG4-related disease (IgG4-RD) (n=2), syphillis (n=1) and isolated aortitis.