LVV, whereas in 24/49(48%) patients with already diagnosed but active LVV disease.

Results: Baseline PET was positive in 21 patients(42.9%). According to ASNC recommendations, 19 patients (38.8%) presented a LVG=3, 2(4.0%) a LVG=2, 6(12.2%) LVG=1 and 22 (44.9%) LVG=0. Patients performing PET at disease onset(75%) had higher LVG score than patients performing PET during the disease course (25%),p=0,002. At T0, aortic, carotid, axillary and subclavian SUV did not correlate with inflammatory markers.

Follow up PET/CT studies were performed in 32 patients, 13 (40.6%) with a clinically active disease despite therapy, while 19(59.4%) in clinical remission.

Follow up PET was still positive in 8 patients (25%) with a LVG=3, 10 (31.2%) patients presented LVG=1 and 14 (43.8%) LVG=0. T1 PET/CT study showed a significant reduction of SUV values in descending aorta, left and right subclavian arteries, and left and right axillary arteries when compared with first PET/CT study. According to LVG, 12 patients with active PET/CT study at T0 (19 pts) presented a reduction of LVG from score 2 and 3 to grade 1 or 0 (64.2%) at second PET/CT study. Only 3 patients presented an increased LVG score at T1, while in the other 17 patients T1 PET confirmed the previous score. No significant difference was found between LVG scores according with clinical characteristics, but among 8 patients presenting an active T1 PET, 4(50%) were in clinical remission.

Conclusion: The use of ASNC recommendations for FDG PET/CT in LVV enables to confirm a metabolically active disease in 40% of patients and in 75% of patients at disease onset, suggesting that post-posing the exam could lead to underrate the real extension of disease. Our data, even if limited, suggest that PET/CT could be crucial in management of patients in clinical remission, detecting patients with still metabolically active LVV. Further prospective studies are necessary to evaluate the role of PET/CT in driving therapeutic strategies.

References:

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THU0307 RESPONSE OF BEHÇET'S REFRACTORY ORAL AND/OR GENITAL ULCERS TO APREMILAST IN COMBINATION VS MONOTHERAPY. NATIONAL MULTICENTER STUDY OF 51 CASES OF CLINICAL PRACTICE

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Background: Apremilast (APR) has demonstrated efficacy in the treatment of oral and/or genital aphthous ulcers in Behçet´s disease (BD). Combination of APR to other disease-modifying anti-rheumatic drugs (DMARDs) has not been assessed.

Objectives: To compare the efficacy and safety of APR in monotherapy or combined with DMARDs in refractory BD.

Methods: National multicenter open-label study on 51 BD patients with oral and/or genital ulcers refractory to conventional treatment.

Results: We included 51 patients (35 women/16 men), mean age 44.7±13.2 years. Before APR, all patients had received several systemic conventional drugs. The main clinical symptoms for starting APR were oral (n=19) and genital (2) aphthous ulcers or both (30).

Excluding corticosteroids, colchicine or NSAIDs, APR was given at standard dose of 30 mg twice daily in monotherapy (n=31), or combined with conventional DMARDs in 16 cases (6 azathioprine, 5 methotrexate, 4 hydroxychloroquine, 4 sulfasalazine, 1 dapsone) or with biologic DMARDs in 4 (2 tocilizumab, 1 adalimumab, 1 infliximab). There were not found statistically significant differences in demographic features, previous therapy, clinical manifestations or reported adverse effects.

After a median follow-up of 6 [3-12] months, most of the patients experienced improvement of the orogenital ulcers in both groups (89.8% in the first 2 weeks), without statistically significant differences. **(TABLE)**

Conclusion: APR leads to a rapid and maintained improvement in most patients with refractory BD orogenital ulcers. APR seems as effective and safe in monotherapy as combined.

TABLE:

	Week 1-2		Week 4		Month 6		Month 12		Month 24	
Outcome of oral and/or genital ulcers n, (%)	**C n=19**	**M n=30**	**C n=19**	**M n=26**	**C n=12**	**M n=17**	**C n=7**	**M n=6**	**C n=1**	**M n=1**
Complete resolution	8 (42.1)	11 (36.7)	12 (63.2)	20 (77)	7 (58.4)	14 (82.4)	3 (42.8)	3 (50)	1 (100)	1 (100)
Partial resolution	9 (47.4)	16 (53.4)	7 (36.8)	3 (11.5)	5 (41.6)	2 (11.7)	4 (57.2)	3 (50)	0	0
No response	2 (10.5)	3 (9.9)	0	3 (11.5)	0	1 (5.9)	0	0	0	0
p value	0.9		0.1		0.1		0.8		0.7	

Abbreviations: C= combined; M= monotherapy; n= available data.

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THU0308 COMPARISON OF CHILDHOOD-ONSET VERSUS ADULT-ONSET TAKAYASU ARTERITIS: A STUDY OF 141 PATIENTS FROM TURKEY

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Background: Childhood-onset Takayasu Arteritis (c-TAK) may differ from adult-onset Takayasu Arteritis (a-TAK) in clinical maaifestations and treatment.
Objectives: To compare c-TAK with a-TAK patients for vascular involvement, disease activity, damage, and treatment.
Methods: Patient charts from two tertiary-care centers of a pediatric and adult clinic were reviewed. Adult patients diagnosed before the age of 18 were included in the c-TAK group. The activity was assessed with the physician's global assessment (PGA) and Indian Takayasu Clinical Activity Score (ITAS). The damage was evaluated with Takayasu Arteritis Damage Score (TADS) and Vasculitis Damage Index (VDI).
Results: Twenty four c-TAK and 121 a-TAK patients were compared. 21 (88%) of the c-TAK group and 104 (89%) of the a-TAK group were female. Age at symptom onset was 14 (IQR: 9-15) for c-TAK and 30 (IQR: 24-43) for a-TAK patients. Diagnostic delay in months was shorter for c-TAK patients [c-TAK: 3 (1-10) vs. a-TAK: 12 (5-58)]. Follow-up duration was similar [53 months (IQR: 16-131) vs. 68 (IQR: 30-102), p=0.763].
ITAS was comparable for c-TAK and a-TAK patients on the first visit [14 (SD: 7) vs. 13 (SD: 5), p=0.362, respectively]. However, the PGA score was higher in the c-TAK group compared to the a-TAK group [9 (IQR 7-10) vs. 7 (IQR 6-8), p<0.001].
14 (64%) of c-TAK patients and 10 (9%) of a-TAK patients received pulse glucocorticoids, p= 0.002. Cumulative glucocorticoid dose was 10 grams (IQR: 6-13) for c-TAK patients and 7 grams (IQR: 4-12) for a-TAK patients (p=0.128).
After diagnosis, children had more vascular interventions than the adults did [9 (38%) vs. 20 (18%), p=0.031, respectively].
Rates of achieving at least one remission were lower for c-TAK patients [c-TAK: 12 (50 %) vs. a-TAK: 94 (82%), p=0.001]. c-TAK patients had a PGA score of 6 (IQR 3-8), the PGA score in a-TAK patients was 1 (IQR 1-3), p<0.001. Still, ITAS was similar for both groups [c-TAK: 1 (IQR 0-3) vs. a-TAK: 0 (IQR 0-2), p= 0.579]. 9 (38%) of c-TAK patients had at least one relapse, and the 43 (38%) of a-TAK patients had at least one relapse (p=0.960).
TADS was similar [c-TAK: 8 (IQR 4-12), a-TAK: 8 (IQR 6-10), p=0.919]. However, VDI of the a-TAK patients was higher than the c-TAK patients [c-TAK: 4 (IQR 2-5), a-TAK: 5 (IQR 3-7), p=0.017]. Glucocorticoid related damage was higher in a-TAK patients (Diabetes: 8% vs. 4%, avascular necrosis: 6% vs. 0, and cataracts: 11% vs. 0)
Conclusion: Aorta involvement, biologic agent use, and vascular interventions were more common in c-TAK patients. However, cumulative damage was not increased for c-TAK patients which may be partly explained by more common corticosteroid related side-effects in adults.

Table 1. Baseline symptoms, physical examination findings*

	c-TAK (n= 24)	a-TAK (n= 117)	p
SYMPTOMS			
Stroke	1 (4)	8 (7)	1
Carotidynia	0	19 (16)	0.044
Upper Extremity Claudication	5 (21)	72 (62)	<0.001
Hypertension	13 (54)	22 (19)	<0.001
Pulse loss (Radial)	8/23 (35)	62 (58)	0.043
BRUIT			
Subclavian	8 (35)	62 (57)	0.054
Renal	9 (39)	15 (14)	0.014
Abdominal Aorta	11 (48)	9 (8)	<0.001

*Values denote the number (%) of patients

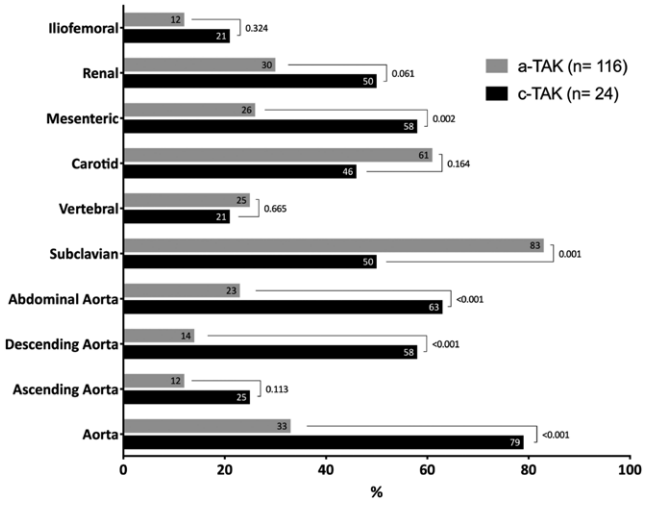

Figure 1. Comparison of involved arteries** Numbers in bars represent percentage of patients in each group

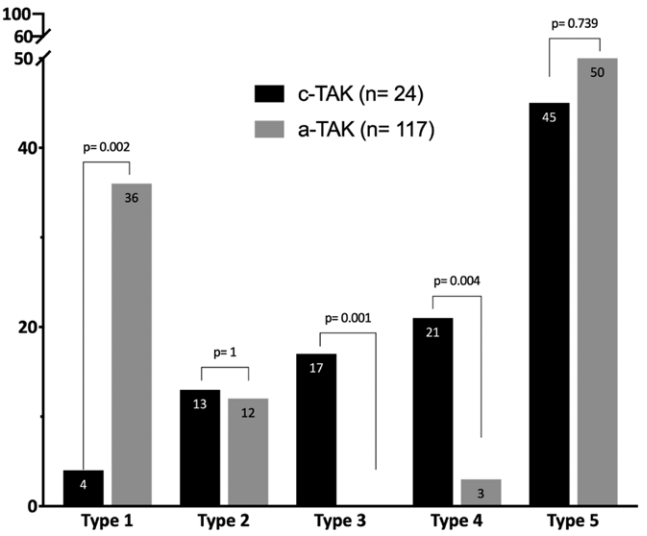

Figure 2. Angiographic classification types according to Hata** Numbers in bars represent percentage of patients in each group. Type 2a and Type 2b are combined. a-TAK group had no patient with Type 3 disease

Table 2. Medical treatment*

	First Treatment			Treated Ever		
	c-TAK (n=22)	a-TAK (n=115)	p	c-TAK (n=24)	a-TAK (n=114)	p
Methotrexate	5 (23)	69 (60)	0.001	12 (50)	76 (67)	0.123
Azathioprine	8 (36)	38 (33)	0.763	21 (88)	79 (69)	0.070
Leflunomide	0	1 (1)	1	3 (13)	35 (31)	0.070
Cyclophosphamide†	6 (27)	6 (5)	0.004	12 (50)	10 (9)	<0.001
Biologics				10 (42)	16 (14)	0.004
Anti-TNF	-	-	-	4 (17)	18 (16)	-
Tocilizumab	-	-	-	7 (29)	4 (4)	-

*Values denote the number (%) of patients.

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THU0309

UNILATERAL TEMPORAL ARTERY BIOPSY IS SUFFICIENT FOR DIAGNOSING GIANT CELL ARTERITIS IF THE SERUM C-REACTIVE PROTEIN LEVEL IS 10 MG/DL OR HIGHER

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Background: Temporal artery biopsy (TAB) is the gold standard for diagnosing giant cell arteritis (GCA). However, previous studies have reported that the discordance rate of TAB is 3-45%, *i.e.*, in unliteral TAB, GCA may be overlooked in one in five patients, approximately. Evidence as to whether bilateral TAB should be performed initially or one-sided TAB is sufficient for diagnosing GCA is lacking.
Objectives: To investigate the predictors of patients with GCA in whom one-sided TAB is sufficient.
Methods: The present study was a cross-sectional, single center study conducted from April 1, 2011 to July 31, 2019 at Tokyo Metropolitan Tama Medical Center. Of all consecutive GCA cases for which bilateral TAB was performed, bilaterally positive cases and unilaterally positive cases were extracted as bilateral positive group (BPG) and unilateral positive group (UPG), respectively. GCA was defined in accordance with the classification criteria of the 1990 American College of Rheumatology, and GCA was diagnosed if no other etiology was found within six months after beginning of high-dose glucocorticoid treatment. Demographic, clinical and laboratory data were obtained from the medical records, and the BPG and the UPG were compared statistically in each variable. Statistical significance was defined as $p < 0.05$.
Results: During study, 264 biopsies were performed for 145 cases, who suspected GCA and underwent TAB. The pathological positivity rate was 26.1% (68 / 264 biopsies). Of these, 53 cases had final diagnosis of GCA, in which 43 cases were biopsy proven GCA. Thirty-seven biopsy proven GCA with bilateral TAB