Venous thrombosis involved 20 patients (90%). They were deep in 16 patients, superficial in one patient and superficial and deep in 3 patients. It was recurrent in 14 patients.
The most common site of deep vein thrombosis was the lower limbs (n=17). The others had unusual sites: inferior vena cava thrombosis (n = 3), superior vena cava thrombosis (n = 2), sus-hepatic vein (n=1) and upper limb thrombosis (n = 1). Pulmonary embolism was noted in one case.
Arterial damage involved 4 patients (20%) divided into arterial aneurysms (3 cases) and arterial thromboses (2 cases). The locations were divided as follows: lower extremity arteries in 2 cases, upper limb arteries in one case, pulmonary artery in 2 cases and abdominal aorta in one case.
Lower limb ischemia had occurred in one patient.
Two patients (10%) had mixed vascular, arterial and venous involvement, confirming the multiple and ubiquitous nature of angio-Behçet.
The treatment was based on colchicine, anticoagulants and corticosteroids in venous thromboses. Immunosuppressive therapy was started in 4 patients in front of the unusual site.
In arterial cases, corticosteroids in combination with immunosuppressant were prescribed. Flattening of the aneurysm was indicated in 2 cases with simple operative follow-up.
Conclusion: Behçet disease (BD) is very common in the Mediterranean basin, mainly affects the 30-year-old man. This systemic disease is characterized by oral aphthosis, genital ulcers and systemic involvement including occular, gastrointestinal, neurological, and vessels that make the severity of the disease.
All types of vessels, regardless of size and seat, may be affected, with venous tropism.
Our study has just supported current literature data regarding the extensive and recurrent venous thrombosis during MB. The seriousness of this venous involvement lies in the involvement of the cavernous veins and in pulmonary embolism.
Arterial damage, such as thrombosis and/or aneurysm, is rare but maybe life-threatening.
Early diagnosis, intensive and appropriate treatment, regular follow-up and the involvement of a multidisciplinary team including internists, vascular surgeons and radiologists are key to better management of patients with angio -Behçet.
Our study illustrates the frequency and significance of vascular involvement in BD.
Disclosure of Interests: None declared
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AB1269 RISK FACTORS ASSOCIATED WITH PERIPHERAL NEUROPATHY (PN) IN ANCA-ASSOCIATED VASCULITIS (AAV):

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Background: Few studies have reported on the risk factors associated with PN in AAV. Vasculitic PN in AAV has been associated with male sex, arthritis, cutaneous, mucous membranes, and ENT manifestations of vasculitis[1,2,3]. PN can lead to life quality impairment, as only 35% of the patients with PN have complete symptoms resolution within 6 months[1].
Objectives: Along with describing the prevalence of incidence of PN in our cohort, we undertook this study to identify the risk factors associated with PN in AAV.
Methods: From 153 AAV patients (defined according to the EMA algorithm), 97 were eligible (complete data and no exclusion criteria -diabetes mellitus, axial disc disease, malignancies, herpetic neuralgia, other comorbidities). Clinical, electromyographic (EMG) and histopathological data were recorded. According to the presence (cases) or absence (controls) of clinical data for PN descriptive analysis is reported as means ± SD or medians (interquartile range-IQR). Categorical variables are reported as percentages. Student t-test and Mann-Whitney U-test were used for continuous variables, two-tailed Fisher exact test to compare proportions differences. To estimate PN predictors, bivariate and multivariate models to establish hazard ratios [HR] were built and analysed with Cox regression.
Results: Thirty-two (33%) patients (19-GPA, 9-MPA, 4-EGPA; 17 prevalent, 15 incident) had PN. Mean age±SD was 47.2±13.0 at vasculitis diagnosis. The median follow-up was 55 months (IQR 37-79) until PN diagnosis. Main symptoms: paresthesias 97%, hypoesthesia 72%, hyporeflexia 53%, burning pain and weakness 47%, mononeuritis multiplex 44%. Diagnostic EMG support in 60%. The estimated incidence rate of PN was of 4/100 persons-year. Differences between cases (n-32) and controls (n-65) were smoking history (p=0.03), drug abuse (p=0.04), and a higher mean BVAS (p<0.001) at AAV diagnosis. The table shows the factors associated with a higher risk for the development of PN. After adjustment for covariates and in a multivariate analysis, a higher BVAS at baseline conferred risk for the presence of PN (HR=1.1, 95% CI 1.03-1.25, p=0.01).

Table. Risk factors for development of PN in AAV expressed as hazard ratios after Cox regression analysis.

Variable	HR (95% CI)	*p* value
Drug abuse history	4.34 (1.2-15.6)	0.025
Arthritis	2.98 (1.01-8.7)	0.04
BVAS at AAV diagnosis	1.13 (1.03-1.23)	0.005

Conclusion: The risk for development of PN is related to overall higher disease activity when AAV is diagnosed. However, it may not be present after many years of its appearance. We had almost the same amount of incident cases than prevalent ones at diagnosis. Therefore, patients with a highly active disease need to be followed up specifically in order to detect PN during the disease course, probably with specialised neurological evaluation.

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AB1270 EVALUATIONS OF ANTIRHEUMATIC DRUGS AT PRECONCEPTIONAL, PREGNANCY AND POSTPARTUM PERIODS OF RA PATIENTS' IN A UNIVERSITY HOSPITAL; PRELIMINARY RESULTS

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Background: Rheumatoid arthritis (RA) spontaneously improves during pregnancy and disease activity decreases in approximately two-thirds of pregnant but this decrease does not last long and postpartum exacerbation can be seen[1].Conversely discontinuation of antirheumatic drug (ARD) during pregnancy may be a risk factor for exacerbation of RA[2]. In case of preconceptional, pregnancy and postpartum (P&P&P) situations during RA treatment, current options are discontinuation of inappropriate medications and switching to appropriate ones. With the latest BSR and EULAR guidelines on prescribing drugs in P&P&P, treatment options expanded with some of the biologic drugs[3,4].
Objectives: The aim of this study is to analyse alterations of ARD use (discontinuation, increasing or switching) at P&P&P periods of RA patients' retrospectively between 2002-2018.
Methods: In our records there are 25 cases of 19 female RA patients who having at least one pregnancy experienced out of 140 RA patients. The data were collected by telephone calls and patient file. Female patients that had no pregnancies after the RA diagnosis were not included. Preconception period was defined as 1 year before estimated last menstrual date. Postpartum period was defined as 1 year after infants' birth.
Results: RA patients participating in our study of 140 female (age median 55 (26-87)), 121 of them (86%) did not give birth after the RA diagnosis. 19 of them (age median 39 (26-61)) had been pregnant after the RA diagnosis (%14) and 14 of them gave birth 1, 4 of them gave birth to 2, one of them gave birth to 3. Twelve out of 140 (9%) patients had postnatal diagnosis. Each of the pregnancies counted as one case so some female patients represented in our data more than ones. While 22 of cases used the ARD before pregnancy (88%), it decreased 18 of

cases (72%) after giving birth. Drug use rate (n=12, 48%) was most lowest particularly 3. trimester and first 3 months after birth (Figure 1). While there was a change such as discontinuation, increasing or switching in the treatment of 15 patients (60%) compared to before and after pregnancy and 6 of them (24%) continued to increase treatment (added drug to preconception treatment). More than half of the patients used steroids and nonsteroidal antiinflammatory drug in all periods (Figure 2).

Conclusion: In conclusion the present study suggests that RA patients and doctors avoid the use of ARDs other than steroids and NSAIDs in P&P&P periods. The fact that 60% of the patients undergoing postpartum drug change were showed that pregnancy affected the RA treatment regimen. The need for steroid and NSAID in a high proportion of patients during P&P&P periods indicates the continuation of RA disease activity and the necessity of strong RA treatments during all these periods.

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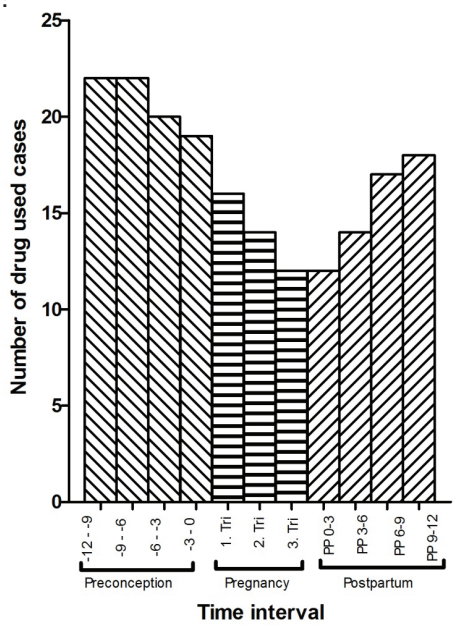

Abstract AB1270 Figure 1. Number of ARD use cases and P&P&P periods (none drug user preconception period, n=3)

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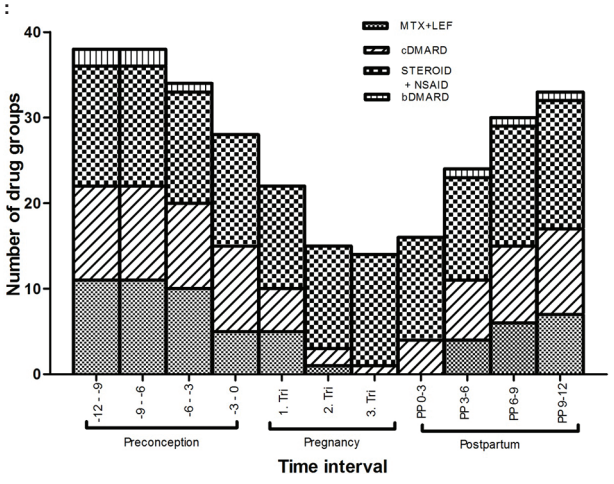

Abstract AB1270 Figure 2. Number of ARD groups and P&P&P periods

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AB1271 **DESCRIPTION OF A COHORT OF PATIENTS WITH SYSTEMIC SCLEROSIS AND ANTINEUTROPHIL CYTOPLASMIC ANTIBODIES (ANCA)**

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Background: The presence of antineutrophil cytoplasmic antibodies (ANCA) in systemic sclerosis (SSc) has been described rarely. The series published in the literature are scarce[1] Its role in the evolution on the disease is unknown

Objectives: To describe the epidemiological and clinical characteristics of ANCA positive patients from a cohort of patients with SSc

Methods: Retrospective observational descriptive study in a cohort of 312 SSc. We analyzed those patients who were positive for ANCA, collecting variables: gender, race, age, age at diagnosis of SSc, at onset of symptoms, type and immunological profile, clinical manifestations of SSc, association with other systemic autoimmune diseases (SAD), capillaroscopic findings, and treatment. Regarding the ANCA profile, pattern, specificity and titration, as the time of evolution of SSc until the appearance of ANCA

Results: Four of 312 patients with SSc had ANCA (prevalence = 1.28%). All were women and 2 had perinuclear pattern. The reason to request ANCA was kidney failure with proteinuria in 2 cases. One patient developed anti-myeloperoxidase (MPO) renal vasculitis and biopsy showed segmental glomerular necrosis and extracapillary proliferation. Other had proteinuria with hematuria without renal failure and biopsy with glomeruli in wafer. Regarding clinical manifestations all ANCA had some degree pulmonary disease 3 interstitial lung disease (ILD)1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization (KT). Three had SAD associated

Characteristics of the sample in table 1

	1	2	3	4
Sex	F	F	F	F
Raynaud's debut/Diagnosis SSc (years)	No/67	72/74	40/41	72/73
Ethnic group	Caucasian	Latin american	Caucasian	Caucasian
Subtype SSc	Diffuse	Limited	Diffuse	Limited
Pattern specificity titration ANCA	N/A	Perinuclear MPO 102.69	Cytoplasmic	Perinuclear PR3 8.0
ANCA diagnosis (years)	1	3	27	1
Antibodies	ANA nucleolar 1/1280 ANTIKU/ RNAPOL 1	ANA speckled 1/640 ACA	ANA nucleolar 1/ 320 ANTIFIBRILARINA/ SRP	ANA speckled 1/1280 ANTIKU/RO52
Autoinmune disease	Graves	Sjögren Primary biliary cirrhosis	Antisintetase	Idiopathic inflammatory myopathy
Kidney		Renal vasculitis Prot 0.52g/L	Membranous nephropathy Microhematuria Prot 0.14g/L	Prot 0.24g/L
Creatinine and GFR pre/post ANCA (mg/dl)	0.72/0.66 >60	0.86/2.13 65/37	0.88/0.7 >60	0.96/0.76 >60
Gastrointestinal		Gastroesophageal reflux	Gastroesophageal reflux	Gastrointestinal Sepsis
Pulmonary	**HAP/NSIP** sPAP 39.2 TAPSE 2.0 cm KT PCP8 TPG35 TDG 15	**No HAP/LIP**	**No HAP/UIP**	No HAP/No ILD sPAP 58 TAPSE 1.4 cm TRV(cm/s)333