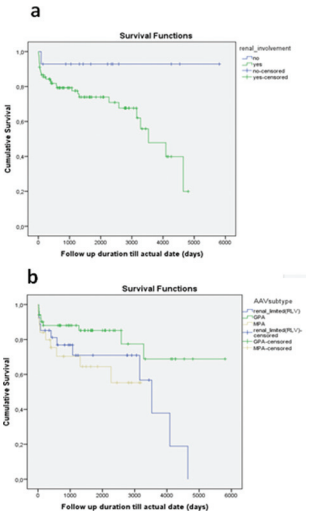


Figure. The results of the Kaplan-Meier analysis. Overall mortality was significantly associated with renal involvement (a) and AAV subgroups (b).

*AAV: ANCA-Associated Vasculitis; GPA: Granulomatosis with PolyAngiitis; MPA: Microscopic PolyAngiitis; RLV: Renal Limited Vasculitis

Disclosure of Interests: Onay Gercik: None declared, Zeki Soypacaci: None declared, Fulya Çakalağaoğlu: None declared, Gokhan Kabadayi: None declared, Idil Kurut: None declared, Dilek Solmaz: None declared, Servet Akar Grant/research support from: MSD, Abbvie, Roche, UCB, Novartis, Pfizer, Amgen, Consultant for: MSD, Abbvie, Roche, UCB, Novartis, Pfizer, Amgen, Speakers bureau: Pfizer

DOI: 10.1136/annrheumdis-2019-eular.4178

FRI0294 CHEMOTHERAPY AND G-CSF INDUCED LARGE VESSEL VASCULITIS AND CAROTIDYNIA – SIX PATIENT CASES AND A SYSTEMATIC LITERATURE REVIEW

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Background: Large vessel vasculitis (LVV) and neutropenic infection in patients receiving chemotherapy present similar clinical symptoms with fever and high inflammation parameters. Infection is more frequent but LVV should be kept in mind as differential diagnosis. LVV is a serious condition which may lead to vessel wall damage. Published few case reports and adverse event reports suggest causal association between LVV and use of granulocyte colony-stimulating factor (G-CSF) and/or chemotherapy (1).

Objectives: To evaluate the rare connection of LVV and anticancer therapy by describing our six patient cases and a systematic review of the literature.

Methods: Between 2016-2018 we identified six patients with probable drug induced LVV associated with chemotherapy and G-CSF. All patients had breast cancer. Systematic literature review was performed according to PRISMA guidelines using comprehensive search terms for breast cancer, chemotherapy, LVV and G-CSF.

Results: In our case series, 5/6 patients developed LVV symptoms within two weeks after administration of docetaxel and G-CSF. Vasculitis symptoms disappeared after drug cessation or drug change.

Literature search identified 16 published case reports with association of LVV and chemotherapy fulfilling our study criteria. Altogether 22 cases were analyzed. Mean age was 59 years (range 40-77 years). In 14/22 cases data from G-CSF administration was available. Time delay from drug administration to LVV symptoms was average 10 days (range 1-42 days) with G-CSF and median 12 days (range 2-310 days) with chemotherapy. Most prevalent cancer types were breast cancer (8/22), hematological malignancies (7/22) and lung cancer (3/22). Most common clinical LVV symptom were fever (18/22), neck pain (11/22) and chest pain (8/22). Diagnosis was confirmed with imaging studies showing vasculitis in various large vessels in upper body. Notably, four cases had vascular inflammation only in carotid region and this was recognized by radiologist as carotidynia/transient perivascular inflammation of the carotid artery (TIPIC) syndrome.

Conclusion: Large vessel vasculitis is a possible serious rare adverse event associated with chemotherapy (possibly docetaxel) and G-CSF. Since signs and symptoms are non-specific, we assume this condition is underdiagnosed and should be kept in mind when treating oncological patients. Successful management requires early identification and cessation of the drug. When diagnosed and treated properly, the recovery is usually fast.

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Disclosure of Interests: Kirsi Taimen Speakers bureau: Pfizer, Novartis, Abbvie, Roche (lectures), Samu Heino: None declared, Ia Kohonen: None declared, Heikki Relas Speakers bureau: Pfizer, Riikka Huovinen Consultant for: Roche, Amgen, Novartis, Pfizer, Speakers bureau: Roche, Amgen, Novartis, Pfizer, Arno Hänninen Speakers bureau: Roche, Laura Pirilä Consultant for: Abbvie, Novartis, Eli Lilly, MSD Finland, Pfizer, UCB, Roche, Jansen- Cilag, Sandoz, Speakers bureau: Pfizer,

DOI: 10.1136/annrheumdis-2019-eular.5009

FRI0295 EVALUATION OF CLINICAL CHARACTERISTICS IN BEHCET SYNDROME BY GENDER AND AGE; A SINGLE CENTER EXPERIENCE WITH 665 PATIENTS

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Background: To evaluate clinical characteristics according to age and gender in patients with Behcet's Syndrome (BS).

Objectives: BS is a systemic vasculitis that affects mucosa, skin, joint, eye, vessels, gastrointestinal system, and central nervous system. The disease characterizes by relapses and remissions, and it is known that prognosis is worse in young males. The aim of this study was to reinvestigate the relationship between the clinical features of BS according to gender and age.

Methods: The data of 665 patients (282 male, 383 female), diagnosed as BS according to the ISG-1990 Behçet's Disease classification criteria, were retrospectively evaluated.

Results: All patients had oral aphthous (OA) ulcers (100%). Eighty-five percent of patients had a genital ulcer (GU), 56.5% had erythema nodosum (EN), 65.9% had papulopustular lesions (PPL), 32.6% had ocular involvement, 49.3% had joint involvement, and 21.7% vascular involvement, and 4.8% had neurobehcet. The incidence rates of PPL, ocular involvement, and vascular involvement were significantly higher in males ($p < 0.001$, $p = 0.004$ and $p < 0.001$, respectively). GU, joint involvement, headache, and pathergy positivity were more common in women ($p = 0.006$, $p < 0.001$, $p < 0.001$ and $p < 0.001$, respectively). Table 1 shows the comparison of the clinical features according to gender. When we compare the mean age of the patients according to the presence or absence of clinical findings; patients with GU, EN, and vascular involvement were found to be younger than those without ($p = 0.006$, $p = 0.025$ and $p = 0.007$, respectively) (Table-2).

Conclusion: Clinical features of BS may vary according to age and gender. Variations can be observed depending on the size of the population, the center where the study is conducted, and the selected-criteria for inclusion. In our study, PPL, ocular involvement and vascular involvement were more frequent in men, whereas GU, joint involvement, headache, and pathergy positivity were more common in women. In addition, GU, EN, and vascular involvement were related to younger ages. Our results were compatible with the BS literature.

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None

Ann Rheum Dis: first published as 10.1136/annrheumdis-2019-eular.4612 on 27 June 2019. Downloaded from http://ard.bmj.com/ on December 11, 2021 at AMS/ANKUNIV*VETERINER P O Box 750. Protected by copyright.

Table 1. Characteristics of patients according to gender

Findings	Patients, n (%)	Male (n=282)	Female (n=383)	OR (95%CI)	p
GU, n (%)	571, (85.9)	230 (81.6)	341 (89)	1.84 (1.18-2.85)	**0.006**
EN, n (%)	376, (56.5)	151 (53.5)	225 (58.7)	1.24 (0.91-1.69)	0.181
PPL, n (%)	438, (65.9)	215 (76.5)	223 (58.2)	0.43 (0.30-0.60)	**< 0.001**
Ocular, n (%)	217, (32.6)	109 (38.7)	108 (28.2)	0.62 (0.45-086)	**0.004**
Joint involvement, n (%)	328, (49.3)	114 (40.4)	214 (55.9)	1.87 (1.37-2.55)	**<0.001**
Vascular involvement, n (%)	144, (21.7)	99 (35.1)	45 (11.7)	0.25 (0.17-0.37)	**<0.001**
GI involvement, n (%)	18, (2.7)	8 (2.8)	10 (2.6)	0.92 (0.36-2.36)	0.859
Headache, (n = 581), n (%)	200 (34.4)	46 (19)	154 (45.4)	3.55 (2.41-5.22)	**<0.001**
Neurobehçet's disease, n (%)	32, (4.8)	13 (4.6)	19 (5.0)	1.07 (0.52-2.21)	0.850
Pathergy positivity (n = 384), n (%)	233 (60.7)	91 (54.5)	142 (65.4)	1.58 (1.05-2.39)	0.029

Table 2. Comparison of the age according to the presence of clinical findings

Findings	n	Median age, years (IQR)	p
GU	(+) = 571	30.4 (11.7)	**0.006**
	(-) = 94	34.1 (12.5)	
EN	(+) = 376	30.3 (11.4)	**0.025**
	(-) = 289	31.5 (13.3)	
PPL	(+) = 438	30.5 (12.0)	0.569
	(-) = 227	30.5 (11.1)	
Ocular	(+) = 217	30.5 (12.0)	0.699
	(-) = 448	30.5 (11.5)	
Joint involvement	(+) = 328	30.5 (12.5)	0.723
	(-) = 337	31.1 (11.4)	
Vascular involvement	(+) = 144	29.6 (10.8)	**0.007**
	(-) = 521	31.2 (12.0)	
GI involvement	(+) = 18	27.8 (10.9)	0.211
	(-) = 647	30.5 (11.8)	
Headache, (n = 581)	(+) = 200	30.4 (12.9)	0.374
	(-) = 381	31.0 (11.6)	
Neurobehçet's disease	(+) = 32	29.5 (7.7)	0.160
	(-) = 633	30.5 (11.8)	
Pathergy (n = 384)	Pozitive:233	30.8 (12.6)	0.446
	Negative:151	30.5 (11.8)	

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.4612

FRI0296 INPATIENT PREVALENCE, MORTALITY, EXPENDITURES AND COMORBIDITIES OF POLYARTERITIS NODOSA: NATIONWIDE INPATIENT SAMPLE 2014

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Background: Polyarteritis nodosa (PAN) is a systemic necrotizing vasculitis that characteristically affects medium-sized arteries of the intestine, kidneys and soft tissue [1]. Little is known about the inpatient burden, expenditures and association with comorbidities of PAN.
Objectives: To investigate the inpatient prevalence, expenditures and comorbidities of patients with PAN using a national inpatient database.
Methods: Patients with PAN were identified from the Nationwide Inpatient Sample (NIS) database of the years 2014 using ICD-9 diagnostic code. NIS is a publicly available inpatient database that contained data of over 7 million hospital stays, which are a 20% stratified sample of over 4,000 non-federal acute care hospitals across all the regions of the United States (US). Data on patient characteristics, comorbidities, resource utilization and expenditures was collected. The primary outcome was determining the inpatient prevalence of PAN in hospitalized patients in the US. Secondary outcomes included determining inpatient mortality, inpatient morbidity (measured by shock, ICU admission and multi-organ failure), comorbidities, hospital length of stay (LOS) and total hospital costs and charges. The most common reasons for hospitalization were abstracted utilizing the top principal diagnoses in patients with PAN. A cohort of patients without PAN was also identified from the same database to serve as comparators for analysis of comorbidities. Multivariate regression analysis was used to adjust for age, gender, ethnicity, Charlson Comorbidity Index, income, hospital region, location, size and teaching status.
Results: A total of 5,255 patients with PAN were included in the study. The mean age was 58.8 years, and 57% were female. The top reasons for hospitalization were PAN itself (15.3%), sepsis (6.9%), acute kidney injury (4.8%) and acute respiratory failure (2.5%). For the primary outcome, the inpatient prevalence of PAN was found to be 14.9 cases per 100,000 admissions. For secondary outcomes, patients with PAN displayed increased adjusted odds of mortality (OR:1.60, p<0.01), shock (OR:1.81, p<0.01), ICU admission (OR:2.06, p<0.01) and multiorgan failure (OR:3.45, p<0.01) compared to patients without PAN. Patients with PAN also displayed significantly higher hospital costs (additional adjusted mean [aAM]: $10,780, p<0.01), hospitalization charges (aAM: $39,915, p<0.01) and LOS (aAM: 4.2 days, p<0.01) compared to patients without PAN. Patients with PAN displayed a significant association with several comorbidities (Table 1).
Conclusion: The inpatient prevalence of PAN was higher than what would be expected from the overall prevalence. The mean total hospital costs and total hospitalization charges for patients with PAN were higher than patients without PAN. Analysis of comorbidities found significantly higher odds of several comorbidities even after adjusting for potential confounders.

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Table 1. Adjusted ORs comparing the prevalence of comorbidities between patients with PAN versus patients without PAN

	Adjusted odds ratio	95% CI	*p*-value
DVT	2.07	1.60-2.66	<0.01
PE	2.12	1.62-2.78	<0.01
AMI	1.27	0.79-2.04	0.32
CHF	1.10	0.92-1.32	0.32
Arrythmia	1.05	0.86-1.29	0.61
Peripheral vascular disease	0.86	0.61-1.19	0.36
Acute kidney injury	4.14	3.54-4.85	<0.01
Chronic kidney disease	9.70	7.69-12.22	<0.01
ESRD	5.51	4.41-6.88	<0.01
Intestinal perforation	3.78	1.59-9.01	<0.01
HBV infection	5.01	2.80-8.95	<0.01
HCV infection	1.65	1.12-2.42	0.01
Sepsis	1.87	1.54-2.28	<0.01

Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2019-eular.6577

FRI0297 CLINICAL FEATURES, TREATMENT MODALITIES AND RELAPSE RATES IN GREEK PATIENTS WITH RETROPERITONEAL FIBROSIS

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Background: Retroperitoneal fibrosis (RPF) is a rare disease of unknown etiology characterized by deposition of fibro-inflammatory tissue around the infra-renal abdominal aorta. The process may involve adjacent structures leading to complications, the most frequent being ureteral obstruction [1]. RPF is mainly idiopathic (iRPF), yet it might be secondary to malignancies, infections, drugs, or radiotherapy [2]. Recent data argue that iRPF could be part of the IgG_4-related diseases [3]. Diagnosis is aided by imaging studies (abdomen CT/MRI), but in patients with newly diagnosed RPF, excluding malignancy is mandatory [2].
Objectives: The aim of our study was a) to describe the presenting clinical, laboratory, imaging features and treatment modalities used in patients

Ann Rheum Dis: first published as 10.1136/annrheumdis-2019-eular.4612 on 27 June 2019. Downloaded from http://ard.bmj.com/ on December 11, 2021 at AMS/ANKUNIV*VETERINER P O Box 750. Protected by copyright.