found between the modified Halo Score and ESR (rho 0.712, p<0.05), haemoglobin (rho 0.703, p<0.05) and platelets (rho 0.734, p<0.05), but not with the other two US scores.

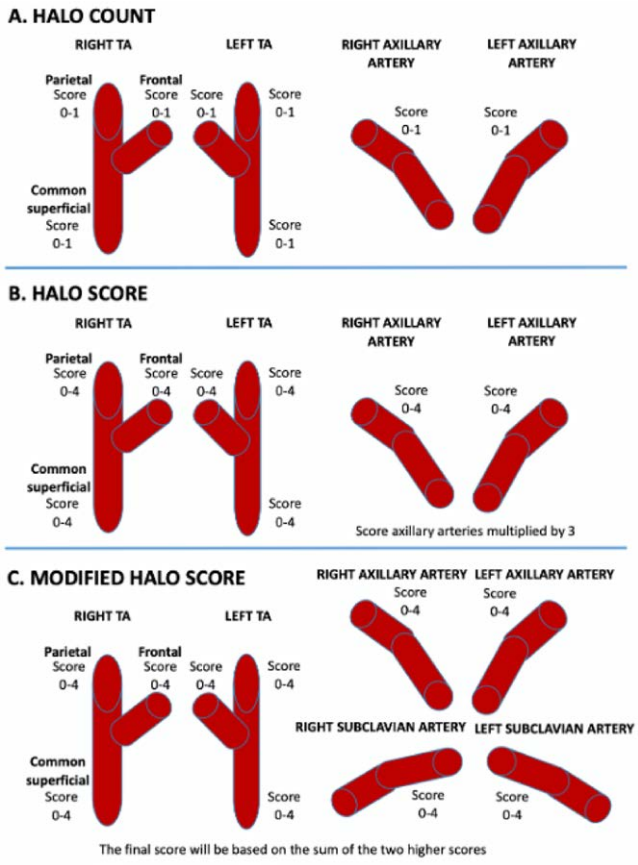

Figure 1. Proposed scores to quantify the extent of vascular inflammation by ultrasound in giant cell arteritis. A. Halo count, B. Halo Score, C: Modified Halo Score

Table 1. Clinical, laboratory and ultrasound findings of patients included in the fast track pathway with or without GCA clinical confirmation.

	Total n=64	Patients with GCA n=17	Patients without GCA n=47	p
Age, median (IQR)	78 (69.3-83)	78 (72.5-83)	78 (66-83)	0.5
Female, n (%)	42 (65.6%)	10 (58.8%)	32 (68.1%)	0.491
Temporal artery biopsy positive n=13, no. of patients	5 (38.5%)	5 (50%)	0 (0%)	0.231
^{18}F-FDG-PET/CT positive n=14, no. of patients	7 (50%)	5 (62.5%)	2 (33.3%)	0.592
Fulfilling 1990 GCA criteria, no. of patients	16 (25%)	8 (47.1%)	8 (17%)	0.022
PMR diagnosis before US examination, no. of patients	21 (32.8%)	4 (23,5%)	17 (36,2%)	0.386
Headache, no. of patients	31 (48.4%)	12 (70.6%)	19 (40.4%)	0.033
Jaw claudication, no. of patients	12 (18.8%)	9 (52.9%)	3 (6.4%)	<0.001
Ocular ischaemia, no. of patients	4 (6.3%)	2 (11.8%)	2 (4.3%)	0.285
Abnormal TA clinical examination, no. of patients	5 (7.8%)	3 (17.6%)	2 (4.3%)	0.112
CRP (mg/dL), median (IQR)	1.7(0-6.5)	7 (2.1-14)	1.1 (0-5.1)	0.001
ESR (mm/h), mean (SD)	52.8 (34.6)	68.3 (33.3)	46.8 (33.3)	0.044
Haemoglobin (g/dL), mean (SD)	12.5 (1.7)	11.8 (1.6)	12.7 (1.7)	0.059
Platelets 10^9/L, mean (SD)	276.1 (105.8)	323.4 (116.3)	258.7 (97.3)	0.52
Positive US findings, no. of patients	17 (26.6%)	15 (88.2%)	2 (4.3%)	<0.001
Temporal artery positive US findings, no. of patients	13 (20.3%)	12 (70.6%)	1 (2.1%)	<0.001
Axillary positive US findings, no. of patients	9 (14.1%)	8 (47.1%)	1 (2.1%)	<0.001
Subclavian positive US findings, no. of patients	5 (7.8%)	5 (29.4%)	0 (0%)	<0.001
Temporal artery + axillary or subclavian positive US findings, no. of patients	5 (7.9%)	5 (29.4%)	0 (0%)	0.003
Halo Count, median (IQR)	0 (0-0.75)	2 (1-4.5)	0 (0-0)	<0.001
Halo Score, median (IQR)	0 (0-4.5)	18 (7-22.5))	0 (0-0)	<0.001
Modified Halo Score, median (IQR)	0 (0-2.75)	8 (3-13.5)	0 (0-0)	<0.001

Conclusion: The inclusion of subclavian arteries examination in the modified Halo Score does not improve the diagnostic accuracy of GCA. Nevertheless, it correlates better with markers of systemic inflammation in LV-GCA

Disclosure of Interests: None declared

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POS0813 FERTILITY AND PREGNANCY OUTCOMES IN TAKAYASU'S ARTERITIS

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Background: Takayasu's arteritis (TA) is commonly seen in women of childbearing ages; therefore, reproductive health of TA patients is an important issue.

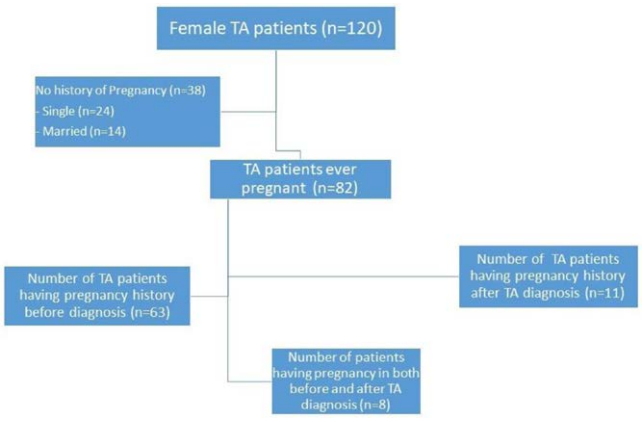
Objectives: We aimed to evaluate the fertility and pregnancy (PG) outcomes of TA patients before and after diagnosis.

Methods: In the prospective database of the Hacettepe University Vasculitis Research Centre (HUVAC), 202 TA patients (female =184) meeting the 1990 ACR criteria were registered by the end of February 2020. 120 patients who could be reached out gynaecological records and marriage status, were included in the study. We identified 233 PG in 82 of included these 120 TA patients (Figure 1). Demographic and clinical features, comorbidities, distribution of vascular involvement, obstetrical histories and outcomes were retrospectively evaluated. Patients were classified according to a novel proposed disease clusters (C1: Abdominal Predominant, C2: Aortic Arch Predominant, C3: Focal Disease) using the defined decision tree.

Results: 12 of 96 (12.5%) married TA patients had infertility being defined as not being able to get pregnant after one year (or longer) of unprotected sex. 20 (16.7%) women had menopause before the age of 45, being defined as early menopause (EM). Compared to normal population, infertility (12.5% vs. 8.1%) and EM ratios (16.7% vs. 7.6%) seem to be increased in TA patients. (1, 2)

200 PG had occurred before TA diagnosis (bTA) in 71 women, and 33 PG were observed after TA diagnosis (aTA) diagnosis in 19 women (two patients diagnosed during PG). According to novel disease subsets, aTA patients classified into C1 (n=3; 15.7%), C2 (n=9; 47.3%) and C3 (n=6; 31.5%). One patient could not be classified.

GHT was seen in 4 (12.1%) patients being the most frequent maternal complication in aTA group. Most common fetal complications were prematurity, IUGR and LBW in both groups (Table 1). Even fetal complications were more frequent in aTA group, it was not statistically significant [11 (33.3%) vs. 43 (21.5%), p=0.18 respectively]. However, maternal complications were significantly more common in aTA group [22 (11.0%) vs. 8 (24.2%), p=0.048]. There was no difference for the obstetrical outcomes in terms of novel TA classification.



Conclusion: This study showed increased infertility and EM ratios in TA patients. PG of aTA had more complications in terms of maternal complications. Fetal complications were more frequent in PG of aTA but not statistically significant. Larger cohort data is required.

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[1] doi:10.1017/s0021932017000244.
[2] doi:10.1016/j.maturitas.2019.03.008.

	Pregnancies		p
	Before TA (n=200)	After TA (n=33)	
Number of Patients	71	19	*NP*
Age at TA diagnosis, years mean (SD)	38.2 (13.1)	24.0 (6.6)	
Age at first pregnancy	21.7 (5.0)	27.6 (5.0)	
Comorbidities/CV Risk factors n(%)	**n (%)**		**p**
- Smoking	22 (31)	3 (15.8)	>0.05
- Dyslipidemia	14 (19.7)	1 (5.3)	
- Hypertension	29 (40.8)	9 (47.4)	
- Diabetes mellitus	8 (11.3)	0 (0)	
Maternal Complications	**n (%)**		
Numbers of pregnancies with any maternal complications	22 (11.0)	8 (24.2)	0.048
- Gestational hypertension	6 (3.0)	4 (12,1)	*NP*
- PROM	6 (3.0)	1 (3.0)	
- GDM	0 (0)	0 (0)	
- Bleeding (Antepartum/ postpatum)	6 (3.0)	2 (6.1)	
- Preeclampsia	0 (0.0)	0 (0.0)	
- İnfection	5 (2.5)	1 (3.0)	
- Placenta previa	0 (0)	1 (3.0)	
Fetal Complications	**n (%)**		**p**
Numbers of pregnancies with any fetal complications	43 (21.5)	11 (33.3)	0.180
- LBW	16 (8.0)	6 (18.2)	*NP*
- IUGR	20 (1.0)	5 (15.2)	
- Preterm birth	13 (6.5)	7 (21.2)	
- CNS complications	2 (1.0)	1 (3.0)	
- Cardiovascular complications	3 (1.5)	0 (0)	
- RDS_BPD	4 (2.0)	0 (0)	
- NICU admission	12 (6.0)	1 (3.0)	
- Other	5 (2.5)	0 (0)	
- Neonatal death	5 (2.5)	0 (0)	
- Retinopathy of prematurity	1 (0.5)	0 (0)	
- Stillbirth	7 (3.5)	0 (0)	
Delivery	**n (%)**		**P**
Vaginal delivery	128 (64)	6 (18.2)	<0.001
Cesarean	24 (12)	13 (39.4)	<0.001
Spontaneous abortus	21 (10.5)	7 (21.2)	0.088
Termination of pregnancy	18 (9.0)	7 (21.2)	0.061

Abbreviations: BPD: Bronchopulmonary dysplasia, **CNS:** Central nervous system, **GDM:** Gestational diabetes mellitus, **IUGR:** Intrauterin growth restriction, **LBW:** Low birth weight, **NICU:** Neonatal Intensive Care Unit, **NP:** Not performed **PROM:** Premature rupture of membranes, **RDS:** Respiratory distress syndrome

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POS0814

DRUG RETENTION RATE, REASONS FOR DISCONTINUATION AND OUTCOME OF INFLIXIMAB USE IN BEHÇET SYNDROME

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Background: Infliximab (IFX) plays a key role in the management of severe and refractory manifestations of Behçet syndrome (BS). However we had previously shown that its sustained use may be limited due to adverse events and lack of patient compliance (1).
Objectives: To assess the retention rate of IFX, adverse events, causes of discontinuation and outcome after cessation of IFX in a larger group of BS patients who were followed in a tertiary center.
Methods: The charts of BS patients who were prescribed IFX between 2004 and 2020 were reviewed to determine demographic features, reasons for IFX use, previous and concomitant drugs, IFX duration, reasons for cessation of IFX and time to flare following cessation of IFX. Follow-up was censored on March 2020.
Results: A total of 252 patients (195 men, mean age 40±10 years) received IFX for uveitis (n=122), vascular involvement (n=82), parenchymal neurologic involvement (n=32), gastrointestinal involvement (n=11), arthritis (n=10), mucocutaneous involvement (n=4), and secondary amyloidosis (n=1). Ten patients had more than 1 involvement requiring IFX.
During a median follow-up of 52 (IQR: 30-88) months, 122 (48%) patients were still receiving IFX for a median period of 33 (IQR: 15-56) months while 130 (52%) patients had discontinued IFX after a median follow-up of 17 (IQR: 7-31) months. Reasons for discontinuation were remission in 25 (19%) patients, adverse events in 39 (30%), lack of efficacy in 23 (18%) (4 primary and 19 secondary), lack of patient compliance in 36 (28%), pregnancy in 4, and preparation for surgery in 3 patients.
Adverse events (n=39) that required the cessation of IFX were infusion reaction (n=17), infection (n=7), hepatotoxicity (n=4), malignancy (n=4), palmoplantar psoriasis (n=3), lichen planus (n=1), drug induced lupus (n=1), splenic infarction (n=1), and a decrease in left ventricular ejection fraction (n=1).
Among the 25 patients who discontinued IFX due to remission, 5 (20%) had a relapse after 4, 21, 26, 29, 38 and 46 months. The remaining patients did not experience a relapse during a median follow-up of 35 (IQR: 24-68) months.

Reasons for infliximab treatment	No of patients	No (%) of patients who were still receiving infliximab	Number (%) of patients who discontinued infliximab	Reasons for discontinuation	Duration of infliximab use (median (IQR) months)
Eye involvement	122	59 (48)	63 (52)	Remission (n=17) Inefficacy (n=10) Lack of patient compliance (n=19) Adverse event (n=12) Others (n)=5)	28 (12.5-52)
Vascular involvement	82	40 (49)	42 (51)	Remission (n=10) Inefficacy (n=7) Lack of patient compliance (n=12) Adverse event (n=12) Others (n=4)	18.5 (9-33.5)
Parenchymal neurologic involvement	32	21 (66)	11 (34)	Adverse event (n=8) Inefficacy (n=2) Lack of patient compliance (n=1)	25 (14.5-50)
Gastrointestinal involvement	11	4 (36)	7 (64)	Remission (n=1) Inefficacy (n=1) Adverse event (n=2) Lack of patient compliance (n=4)	7 (2-17)
Joint involvement	10	2 (20)	8 (80)	Inefficacy (n=1) Adverse event (n=5) Lack of patient compliance (n=2)	20 (4-35)
Mucocutaneous involvement	4	3	1	Inefficacy (n=1)	6, 10, 12, 104 months
AA amyloidosis	1	0	1	Inefficacy (n=1)	6 years

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