Results: A 60 year old man presented to the surgeons with an itchy, non-tender lump over his left temple and lethargy. PV was normal. Doppler ultrasound revealed a thrombosed temporal artery. Biopsy confirmed GCA.

Three months after stopping two years of prednisolone he represented with sweats, weight loss and an itchy right temple, again without headache. CRP and PV were raised and repeat biopsy showed active GCA. Restarting prednisolone led to resolution of symptoms and inflammatory indices.

An 89 year old lady presented to dermatology with a scalp, malaise and forearm pain. Examination revealed unrecordable blood pressure, absent radial and brachial pulses. Bloods showed raised PV and anaemia. A history of tongue pain on eating and a non-pulsatile temporal artery were elicited. After starting prednisolone the skin lesion healed and PV normalised.

A 68 year old lady presented to the physicians with dizziness, malaise and forearm pain. Examination revealed unrecordable blood pressure, absent radial and brachial pulses. Bloods showed raised PV and anaemia. A history of tongue pain on eating and a non-pulsatile temporal artery were elicited. After starting prednisolone the skin lesion healed and PV normalised.

Conclusion: Rheumatologists need to ensure other clinicians are aware of atypical presentations of GCA to avoid unnecessary investigation and delays in diagnosis.

doi:10.1093/rheumatology/keh765

PP12. AORTIC AND EXTRA-CRANIAL LARGE VESSEL GIANT CELL ARTERITIS IN A PATIENT WITH SEROPOSITIVE RHEUMATOID ARTHRITIS ON METHOTREXATE

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Background: In giant cell arteritis (GCA) 10-15% patients have involvement of the aortic arch, the descending aorta and its branches. The number of case reports of GCA with seropositive rheumatoid arthritis (SPRA) is small.

Methods: We describe “aortic syndrome” GCA in a patient with SPRA on methotrexate.

Results: A 71 year old lady with eight years of erosive SPRA on methotrexate 15 mg weekly complained of five months of night sweats, malaise and forearm pain. Further questioning revealed forearm pain and Raynauds without arthralgia, headache, scalp tenderness, jaw claudication or visual disturbance. Examination showed no synovitis or cutaneous vasculitis but radial and brachial artery pulsation were absent and subclavian bruits present. Blood pressure in the upper limbs was unrecordable. Temporal arteries were non-tender.

Blood tests showed PV 2.45, CRP 118, ALP 180, haemoglobin 8.8, platelets 655 (all relatively normal six months previously).

MR angiography showed left vertebral, bilateral subclavian and axillary artery occlusion with collateral vessel formation and soft tissue swelling. CT angiography of the abdominal aorta demonstrated oedema and stenosis of the superior mesenteric and right renal artery. Temporal artery biopsy confirmed GCA.

Prednisolone was commenced and at two week review she was asymptomatic with PV 1.7 and CRP 1.

Conclusion: Classic GCA developing in SPRA patients has been reported infrequently. Both conditions may share pathogenic mechanisms and are associated with HLA DR4. GCA affecting the aorta and large branches is uncommon and to our knowledge there are no reported cases (including rare involvement of the renal artery) in SPRA.

doi:10.1093/rheumatology/keh766

PP13. PHASE II STUDY OF THE SAFETY AND EFFICACY OF INFlixIMAB IN GIANT CELL ARTERITIS (GCA): 22 WEEK INTERIM ANALYSIS

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Background: Although GCA is responsive to glucocorticoids (GCS), therapy causes significant toxicity and often fails to induce sustained remission.

Purpose: Assess safety and efficacy of infliximab (IFX) in patients (pts) with new onset GCA in a randomized, double-blind, placebo-controlled, multi-center, Phase II study.

Methods: Eligibility: diagnosis of GCA (ACR criteria); GCA of ≤4 weeks (wks) duration; resolution of GCA features and normal ESR following treatment with 40–60 mg prednisone or prednisolone/day; remission for 1 wk prior to randomization. Exclusions: absence of infection, malignancies within 5 yrs, congestive heart failure and advanced disease of critical organs.

Treatment randomization: 1:2 ratio, to receive infusions of placebo or IFX 5 mg/kg, respectively, at wks 0, 2, 6, 14, 22, 30, 38, 46. All pts received GCS on a specified tapering schedule with starting dose of GCS.

Secondary endpoints were: (i) proportion of relapse-free patients through wk 22 and safety (frequency and types of adverse events). Relapse definition: rise in ESR, normal E SR ≥40 mm; and one of following (i) 1 or more specified features of GCA; and (ii) any other features of GCA not attributable to any other cause and a concomitant increase in dose of GCS.

Secondary endpoints included: (i) proportion of relapse-free patients at wk 54; (ii) time to 1st relapse; and (iii) cumulative dose of GCS.

Results: 44 pts were randomized (placebo, n = 16, IFX, n = 28) at 22 centers in 5 countries. Mean age in both groups (gps) was 71.0 years (range: 50–93). Baseline features between gps were comparable except for gender (placebo 31.3% males vs 40.0% IFX) and one of following: (i) 1 or more specified features of GCA; and (ii) any other features of GCA not attributable to any other cause and a concomitant increase in dose of GCS.

Efficacy: At wk 22, (i) 14.3% IFX had at least 1 relapse vs 38.5% placebo (p = 0.016). (ii) Cumulative GCS dosage at wk 22: IFX 17% placebo 38% (p = 0.016). (iii) Cumulative GCS dosage at wk 46: IFX 34% placebo 66% (p = 0.016). IFX-treated pts had significantly lower cumulative GCS dosage.

Conclusions: Infliximab was well tolerated and maintained GCA remission longer than placebo.