toxicity and two had treatment failures. CRP, ESR and periaortic tissue thickness variations during the follow-up are shown in Supplementary data (respectively in panel A, B and C; red line represents the average change): ESR and CRP significantly decreased \( (P = 0.001 \text{ and } P = 0.006 \) at month 12 versus baseline) while a reduction in periaortic tissue thickness was also observed although non-statistically significant. The periaortic tissue evolution in one patient at baseline, month 6 and 12 is reported in panel D, E and F of Supplementary data. At month 12 an increase of periaortic tissue evolution in one patient at baseline, month 6 and 12 is reported although non-statistically significant; moreover of the six patients presenting with obstructive uropathy, only one had hydronephrosis and two an ureteral stent at month 12. The patients who continued treatment beyond month 12 had a longer relapse-free survival than those who withdrew it \( (P < 0.005) \).

**Conclusion.**– The combination of methotrexate and prednisone is a feasible option for relapsing CP. Prolonged treatment is likely to avoid further relapses.

**Supplementary data associated with this article can be found on the website of *La Presse Médicale* (http://www.em-consule.com/revue/lpm).**

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**P92**

**Outcome of 1516 percutaneous interventions in 401 patients with Takayasu arteritis – a single-center experience from South India**

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**Introduction.**– During 1996–2012, 401 patients with Takayasu arteritis (TA; age 29 ± 12 years, range 4–64 years; 297 females; type-%: I-18, II-9, III-6, IV-16, V-51), all of whom met clinical criteria for TA (88% also met ACR criteria), underwent 1516 percutaneous interventions (PI) to treat 1044 lesions (712 stenoses, 317 occlusions, 15 aneurysms; 77% symptomatic; PI/lesion 1.45, range 1–7) in large-vessels (aorta 168, renal 253, carotid 159, subclavian 285, mesenteric 85, others 94) at a tertiary care center; at PI-1, 54% had both ESR > 20 mm/hr and CRP > 6 mg/L, 28% either, and 18% neither; all received long-term immunosuppressive therapy.

**Methods.**– Obstructive lesions were dilated at 12 ± 6 atm pressure (15% needed ≥ 20 atm); 869 (83%) lesions were stented; stented segment length was 50 ± 42 mm, range 6–250 mm. Non-compliant balloons (25%) and cutting balloons (12%) were used for resistant lesions. Early and follow-up (FU) outcomes were analyzed. PI success was defined as < 50% residual stenosis/excluded aneurysm without major complications; ≥ 50% stenosis at FU was considered re-stenosis (RS).

**Results.**– Early outcome of 1044 PI-1 procedures was: success 974 (93%), sub-optimal/complicated 47 (5%), failure to cross occlusion 23 (2%). FU obtained in 659 PI-1 lesions: 308 (47%) had sustained success, but 351 had RS. PI-2 was done on 317 RS lesions: 205 had FU, 91 (44%) success, 114 RS-2; similarly, PI-3: 101 lesions, 63 FU, 21 (33%) success, 42 RS-3; PI-4: 40 lesions, 25 FU, 12 (48%) success, 13 RS-4; PI-5: 10 lesions, 6 FU, 3 success, 3 RS-5. The cumulative benefit of repeated PI yielded an overall success rate of 435/503 (87%, uncrossable and FU-awaited lesions excluded) at a mean FU of 33 ± 34 months after the final PI. Significant complications were: death 6 (0.4%), arterial rupture 22 (1.4%), intracranial bleed 8 (0.5%), stent thrombosis 22 (1.4%) (table 1).

**Table 1**

<table>
<thead>
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<th>Vessel-specific outcome.</th>
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<tbody>
<tr>
<td>Lesion location</td>
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</tr>
<tr>
<td>Number of lesions at FU</td>
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<tr>
<td>Angiographic FU (%)</td>
</tr>
<tr>
<td>FU duration (months)</td>
</tr>
<tr>
<td>Original occlusion</td>
</tr>
<tr>
<td>Active disease at PI-1 (%)</td>
</tr>
<tr>
<td>Average number of PI-1</td>
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<td>Successful outcome</td>
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FU: follow-up after final percutaneous intervention (PI); PI-1: first PI.

**Conclusion.**– Repeated PI using contemporary techniques to treat large-vessel lesions in TA yield high sustained success rates with low related risk.

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**P93**

**Aortic dissection in giant cell arteritis: A population-based study of predictors**

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**Introduction.**– Aortic manifestations are associated with increased mortality in giant cell arteritis (GCA). Size is a main determinant of aortic dissection (AD) in aortic aneurysms (AA) from non-inflammatory causes. Our aim was to explore risk factors for AD in patients with GCA and AA.

**Methods.**– We used a population-based incident cohort of patients diagnosed with GCA from 1950–2004. All patients with AA in the 1 year prior to GCA diagnosis or any time thereafter were included. Cox proportional hazard models were used to evaluate risk factors for AD.

**Results.**– The study included 33 patients (91% women), mean age at diagnosis of AA 83.6 years. Median duration of GCA prior to diagnosis of AA was 8.7 years. Location of AA was thoracic in 13 (39.4%), abdominal in 5 (24.2%) and both thoracic and abdominal in 12 patients (36.4%). Eight patients developed AD (3 AD diagnosed same time as AA). Increasing age (HR 0.27 per 10 yrs, 95% CI 0.09, 0.86) and calendar year of AA diagnosis (HR 0.29 per 10 yrs, 95% CI 0.13, 0.69) were associated with decreased risk of AD. Cumulative glucocorticoid dose (HR 0.94, 95% CI 0.82, 1.07) or cumulative erythrocyte sedimentation rate (ESR) (HR 0.98, 95% CI 0.96, 1.00) were not associated with AD.

Mean size of thoracic AA in 4 patients with dissection was 8.4 (range 4.5–5.0) cm compared to 4.97 (range 3.2–8.4) cm in 15 patients without AA \( (P = 0.65) \). Size of the AA at diagnosis (HR 1.33, 95% CI 0.40, 4.42) or maximal size of thoracic AA (HR 1.17, 95% CI 0.69, 1.99) was not associated with AD.

**Discussion.**– Decreased risk of AD among older patients with AA may indicate mortality from other causes before the AA could be clinically symptomatic whereas technological advances in imaging and/or surgery may have led to the observation of decrease in AD with calendar year of AA diagnosis.