tribution. Survival characteristics were calculated using the Kaplan-Meier method.

**Results.** Between 2000 and 2010, 82 patients were diagnosed with GPA or MPA (F/M:44/38). Cases were classified into the five subgroups (Table I). Compared with the EUVAS patients CV AAV was less frequent and GI AAV more frequent. The two types of renal AAV were of comparable frequency. The overall incidence of AAV was 16.2/1,000,000 (12.9–20.2). The median follow-up was 5.36 years (0.05–12.2 y). The 2 year survival was worst in the GI AAV group (70%) and best in the renal PR3 group.

**Discussion.** In our cohort, the five subgroups of AAV have distinct survival curves supporting the idea that subcategorization of AAV would be useful in predicting outcome. The proportion of patients classified into each group is similar to the EUVAS trial. We have confirmed in an unselected population that PR3+ve renal vasculitis has a better outcome than renal vasculitis without PR3 and also that GI AAV is associated with a worse outcome.

**Conclusion.** We have confirmed using the Mahr algorithm in an unselected cohort results in a similar classification to the trial patients.

**Reference**

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**A26**

**A myelopoiesis gene signature during remission in ANCA-associated vasculitis reflects ongoing prednisolone therapy and does not seem to predict relapses**

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**Introduction.** A myelopoiesis gene signature in circulating leukocytes, exemplified by increased mRNA levels for MPO and PR3, has been reported in ANCA-associated vasculitis (AAV), possibly related to disease activity. We explored its relation to subsequent relapses, treatment, selected intracellular transcription factors and microRNAs (miRs).

**Patients.** RNA was isolated from peripheral blood mononuclear cells (PBMCs) and polymorphonuclear cells (PMNs) in 67 AAV patients (45 MPA, 22 GPA) and 27 controls. mRNA for PR3, MPO, transcription factors and miRs were analyzed with Taqman qPCR. Patients were followed prospectively for 10–23 months.

**Results.** Patients had higher mRNA levels in PBMCs for MPO and PR3, and in PMNs for PR3. Patients with active disease (n = 6) tended to have higher elevated levels. 11 patients developed relapses during follow-up; their mRNA levels were not elevated compared to those who remained in remission. mRNA levels did not differ based on treatment with Azathioprine, Mycophenolate or Methotrexate, but correlated to steroid doses. Steroid-free AAV patients (n = 16) had levels similar to controls. In controls mRNA levels for MPO and PR3 were correlated to C/EBP-α in PBMCs but such a correlation was not seen in AAV patients. In controls both PR3 and MPO mRNA levels correlated to miR-29a, -93 and -142-3p. In AAV patients there were no significant correlations between PBMC miR levels and mRNA for MPO/PR3. Also in PMNs from controls there were several positive correlations between miRs and MPO/PR3 mRNA that were not present in PMNs from AAV patients.

**Conclusion.** The regulation of MPO and PR3 mRNA levels seems to differ between AAV patients and controls. Low doses of steroids (2.5–10 mg/day) might be responsible for these differences as well as for the myelopoiesis gene signature seen in AAV during remission. mRNA levels for PR3 and MPO do not seem to reflect subclinical disease activity or predict relapses. If these findings relate to the therapeutic effect of steroids in AAV remains unknown.

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**A27**

**ENT involvement is related to better renal function in patients with ANCA-associated vasculitis**


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