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 ($P = 0.001$ 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 eGFR improvement was also observed although non-statistically significant; moreover of the six patients presenting with obstructive uropathy, only one had hydrourephrosis 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 *Presse Médicale* (http://www.em-consulte.com/revue/lpm).

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**Table I**

**Vessel-specific outcome.**

<table>
<thead>
<tr>
<th>Lesion location</th>
<th>Aorta</th>
<th>Renal</th>
<th>Carotid</th>
<th>Subclavian</th>
<th>Mesenteric</th>
<th>All vessels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lesions at FU</td>
<td>89</td>
<td>112</td>
<td>97</td>
<td>176</td>
<td>42</td>
<td>503</td>
</tr>
<tr>
<td>Angiographic FU (%)</td>
<td>73</td>
<td>86</td>
<td>87</td>
<td>73</td>
<td>93</td>
<td>83</td>
</tr>
<tr>
<td>FU duration (months)</td>
<td>32 ± 36</td>
<td>42 ± 40</td>
<td>38 ± 37</td>
<td>29 ± 28</td>
<td>28 ± 30</td>
<td>33 ± 34</td>
</tr>
<tr>
<td>Original occlusion</td>
<td>6 (7%)</td>
<td>12 (11%)</td>
<td>37 (38%)</td>
<td>62 (51%)</td>
<td>2 (5%)</td>
<td>130 (26%)</td>
</tr>
<tr>
<td>Active disease at FU (%)</td>
<td>51</td>
<td>59</td>
<td>48</td>
<td>48</td>
<td>62</td>
<td>51</td>
</tr>
<tr>
<td>Successful number of FU</td>
<td>1.37</td>
<td>1.38</td>
<td>1.40</td>
<td>1.60</td>
<td>1.43</td>
<td>1.43</td>
</tr>
</tbody>
</table>

FU: follow-up after final percutaneous intervention (PI); PI-1: first PI.

*Presence of both ESR > 20 mm/hr and CRP > 6 mg/L.*

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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**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 IIb: I–II, II–II, III–III, IV–IV, V–V), 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 I).

**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.

**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 8 (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.

**Discussion.**– Mean size of thoracic AA was 4.97 (range 3.2–7) 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.

*Presence of both ESR > 20 mm/hr and CRP > 6 mg/L.*
Introduction. — Although not uniformly accepted, an increased uptake by 18F-fluorodeoxyglucose positron emission tomography (18F-FDG PET) in large-vessels is accepted to be a sign of active disease in Takayasu’s arteritis (TAK). In this study, we aimed to investigate the value of 18F-FDG-PET for clinical assessment in a subset of TAK patients having a persistent acute phase response (APR) without any signs or symptoms of clinical activity.

Methods. — We studied 12 patients with TAK (mean age: 39.2 ± 14.8 years, F/M: 10/2, disease duration: 5.4 years). Patients were clinically inactive (according to the definition of activity by Kerr et al.), while categorized as having “persistent” disease activity by physician’s global assessment due only to APR. All patients were under immunosuppressive treatments including corticosteroids. The severity of large-vessel 18F-FDG uptake was graded using a four-point scale from grade 0 (no uptake present) to grade III (high-grade: uptake higher than liver). Any uptake in major vessels with a grade ≥ 2 was accepted to be “active.”

Results. — Mean ESR was 55.5 (30–86) mm/h and mean CRP was 29.6 (7.7–90) mg/L. Active vasculitic lesions were observed by 18F-FDG-PET in 8 of 12 (66%) of the study group, with a mean number of 2.6 (1–4) active vascular lesions. Arcus aorta was involved in 25%, ascending aorta in 20%, right brachiocephalic artery in 20%, descending aorta in 15%, abdominal aorta in 10% and left and right subclavias in 5% each of the investigated vessels. A step-up treatment change was decided in 7 patients according to 18F-FDG-PET results.

Conclusion. — We observed increased 18F-FDG-PET uptake in the majority of TAK patients with an increased APR, but clinically silent disease. Although specificity of observed lesions are not clear, 18F-FDG-PET imaging may influence physician’s assessment of clinical activity and treatment choices in TAK.

References.


